Clinical Lectures ON SCLERODERMA.

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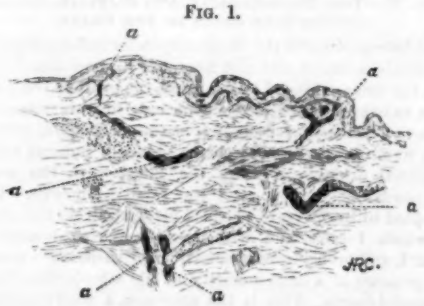
LECTURE II.

CIRCUMSCRIBED AND MIXED SCLERODERMA.

(*Concluded from page 929.*)

IN reviewing these cases, we find that, in addition to what I have just said about distribution, the patches, though usually unilateral, are often bilateral, and occasionally symmetrical or in the median line; that they may be evolved in a few days or take many months to develop; that they are irregular in outline, of variable size, single or multiple, raised, depressed, or level with the surface, sometimes thicker, sometimes thinner than normal, usually yellowish or pinkish white, but often deeply pigmented in various hues, often, but by no means always, surrounded by a vascular zone; that they are atrophic at first, hypertrophic at least in some elements later on, sometimes sharply defined, at others merging imperceptibly into the healthy skin, hairless, smooth or corrugated, not deficient in sensibility, but

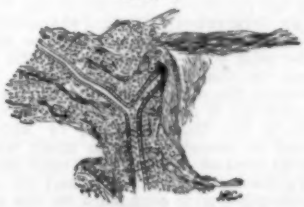
FIG. 1.



the sweat secretion is in abeyance, usually superficial, affecting the skin only, and capable of being pinched up, but sometimes firmly united to the subjacent tissues and even to the bones. This last feature applies chiefly to the bands, which, like the patches, may be sunk into sulci or raised into ridges; in short, it seems to be scarcely possible to make any one statement that would be applicable to all cases, and being a rare disease and so very variable it is desirable that all instances should be recorded.

We will now pass on to the consideration of the anatomy and pathology of this form. The anatomical conditions exemplified in the sections before you are as follows (the changes are almost confined to the corium). Taking the earliest stage, the white atrophic spot which I described to you in the case of Mrs. L——, from whom the specimens were taken, we find many of the vessels of the superficial longitudinal plexus, and the vessels in some of the papillæ, blocked by thrombi; but more frequently the vessels lying horizontally are alone occluded (Fig. 1); as a consequence there is atrophy of many of the papillæ, and in some parts, where the disease is more marked, there is degeneration of the deep cells of the epidermis. Cell masses, apparently leucocytes, lie round many of the vessels like a sheath and diminish their lumen, especially those of the sebaceous glands, hair-follicles, and the sweat-ducts, but not round the deeper lying sweat-glands themselves. A fibro-cellular network connects the cell groups; and vessels can often be traced into the cell masses, and end abruptly as if the vessel had ruptured. The vessels of the deep plexus are not usually affected in this stage, but the connecting vessels of the two plexuses may be. (Fig. 2.) There is no lardaceous or other change visible in the vessel walls. Later on the changes go deeper: there is great increase of the connective and elastic tissues of the corium from fibrillation of the cell effusion which now affects the deeper vessels, involving even the upper layers of the fat, and, by the contraction of the newly-formed fibrous tissue, vessels are obliterated, the sebaceous glands are atrophied, the sweat-ducts obstructed, and occasionally even the sweat-glands also. These anatomical facts will explain the clinical aspects of the disease; the atrophic spots which marked the onset and spread of the patches are produced by the cutting off of the blood-supply below them by the thrombi, and the thrombi are probably produced by cell effusion round the vessels pressing upon the vessel walls and leading to clotting of the blood at or beyond the point of pressure. The atrophic spots are the base of the anæmic devascularised area, and the vascular zone so often seen round the patches is due to the collateral hyperæmia that is usually found round an anæmic area. The pigmentation and small extravasations of blood are the result of the same process of collateral hyperæmia. When the cell effusion organises into fibrous tissue and contracts we get thickening of the deeper part of the affected skin, and the patch is perhaps drawn into wrinkles, as it is not attached to the tissues below, as the skin in the bands usually, and that in the diffuse cases always, is; in these cases the contraction being vertical as well as lateral, the skin is drawn into a furrow in the case of a band, or general shrinking is produced in the diffuse form, in which you may remember the anatomical changes were of a precisely similar character; in fact, the difference lies, in my opinion, solely in this, that in the patches the changes are almost entirely superficial, while in the diffuse form the deeper part of the skin and subjacent tissues and often the muscles and bones are involved, while

FIG. 2.



the superficial part may escape or not. But what preceded and produced this thrombosis and cell effusion the anatomy does not tell us, and we are driven to theorise that the vaso-motor or trophic nerves are at fault, and permit the leucocytes to be effused from their walls, and block to a greater or less degree the blood and lymph flow; for there can be no doubt that the lymph as well as the blood circulation is involved, or we should have simply atrophic spots, such as we saw in the case of William M——, in association with morphœa patches. The treatment in these circumscribed cases is even more unsatisfactory than that of the diffuse form. Nothing internal can influence the disease directly, and our aim must simply be to raise or keep the patient up to as vigorous a condition as his constitution and circumstances permit. With regard to local treatment, I know of none that has any effect for good; but I also know that any irritating application does harm, both in spreading and increasing the thickness of the patch. Judging by the influence of improved circulation in the diffuse form, measures adapted to this end would probably be of benefit, and galvanising the skin in the neighbourhood suggests itself, but I should not recommend it over the patch itself. Fortunately, however, while we can do so little, nature can aid herself; and although she often takes many years to restore the damaged tissues, she eventually nearly always succeeds.

We have now left for consideration the mixed or diffuse unsymmetrical cases, and they will not detain us long. They are but few in number, but are interesting and important because they are links which connect together the other forms that we have been considering.

The first case is the classical one of Elizabeth N——,[1] which has been described by such able pens as those of Addison, Hilton Fagge, and Hutchinson, and is the case selected for the atlas of the Sydenham Society, which

[1] Guy's Hospital Reports, series 3, vol. xiii., 1867.

enables me to show you her portrait and you to realise better the verbal description. I need only describe to you the history of the onset of this extremely interesting case and the distribution of the lesions; individually the lesions are the same in character as those we have already described, but the association of patches supervening on the diffuse disease is very interesting, and also the unilateral character of that condition. The concurrence of ordinary keloid is paralleled in a slight degree by the case of Mrs. L——. Now, I want you particularly to observe that we have two stages in the development of this case: the first marking the onset of the diffuse acute, the second of the chronic circumscribed, form. In the onset of the diffuse part of it we observe it was very sudden, without apparent cause and preceded by œdema. So far these features are not very exceptional, and we have seen them all illustrated in our last lecture,[2] but its distribution was hemiplegic, and did not involve the upper extremity, nor the face at that time, but only the left side of the trunk and the whole of the left leg. The very opposite of what usually occurs, the distribution being usually paraplegic, but involving the upper half of the body. The distribution in this case is that of a spinal hemiplegia in the upper dorsal region. Some time later the second stage set in. The history does not enable us to infer the exact period, although we know that it was within a year, but we only learn the distribution of the new phase three years after the onset of the disease when she came under Dr. Addison's care. This was the stage of the development of patches. They came on slowly as far as can be gathered, and with the exception of those on the face were to a great extent right-sided, no special distribution in a recognisable nerve area was to be made out, but the patches on the left side of the face point to the influence of the fifth nerve, which is a not uncommon distribution for morphœa, as we have already seen. So far as the patches are concerned, there is nothing very unusual either in their development, physical characters, or distribution; it is their association with the diffuse form which is the chief point of interest, and this is rendered still stronger by the following two cases, where the patches preceded the diffuse condition and in one spread from the patch till it involved a larger tract. The first of the two is Mr. Gaskoin's case, to which I have before alluded as remarkable in so many ways that it deserves to be recalled at least in a brief abstract. The patient was a woman aged thirty-five, and the onset of the disease was described with confidence by the patient to a mental shock during pregnancy, and there was no history of rheumatism, gout, or syphilis. The disease was first noticed in the form of two patches on the outer and upper part of the right thigh; the patches increased in number, amounting to about thirty, and were situated more on the anterior than on the posterior surface of the body, rather more on the right side than on the left, and not in corresponding situations, and more on the lower than on the upper limbs. They were depressed in the centre, pigmented in various tints, brown, red, purple, yellow, and yellowish-white, were to some extent anæsthetic, though some were painful and tender, and attended with excessive pruritus. About three years later, after going to the seaside in inclement weather, she returned with "pasty œdema" of the legs and trunk, and the colour returned to the skin very slowly after pressure. The œdema gradually disappeared in the course of the ensuing six months, and simultaneously the skin became sclerosed, spreading from the morphœa patches, which became diffused over a large surface, losing their concavity and defined outline. The patient emaciated, losing two stones in weight, and gradually the whole skin, except the head, became involved, and the patchy was converted into a diffused atrophic scleroderma. At a later period the face was also affected below the forehead, but not the buccal mucous membrane. For the many and other interesting details I must refer you to Mr. Gaskoin's description in the sixtieth volume of the Medical and Chirurgical Transactions.

Here is another somewhat similar case, related by Dr. Dyce Duckworth. A servant, aged sixteen, had some patches of morphœa on the left thigh; seven years later she had an attack of acute rheumatism, and the patches spread and got harder; six months later the left foot and leg got hard and stiff, followed by the right foot and leg, and both forearms and hands, which were sclerodactylous. The disease was symmetrical on the arms and below the knees; there was none above the edge of the patella on the right leg, but there was a streaky band of induration on the left leg, which connected the diffuse part of the disease with the enlarged original patches on the inner and back part of the thigh. In Mr. Gaskoin's case you observe again, after exposure to cold, induration spread from the patches and became general. This is distinctly stated, and is in opposition to the view Mr. Hutchinson takes that morphœa never spreads, but only increases in size by fresh patches forming near and coalescing. Dr. Duckworth also states that after an attack of acute rheumatism the patches spread and got harder, and later diffuse scleroderma developed symmetrically on the extremities.

These three cases, then, show us that the morphœa condition may precede or follow the diffuse form, which in this class of case is always in the shrunken condition; and it appears to me that patchy scleroderma is almost as nearly related to diffuse scleroderma as patchy eczema is to general eczema. But I would have you to understand that while I regard them both as the outcome of the same pathological process, and occurring probably in individuals of the same constitution, the exciting cause of the two forms may be very different in its nature. The pathology, diagnosis, and treatment are the same in this as in the other forms of scleroderma.

[2] As the case has been repeatedly described and commented on, the relation of the case is omitted.

CLINICAL STUDY OF THE LIVER VIEWED THROUGH THE URINE.

BY GEORGE OLIVER, M.D. LOND.

(*Continued from page 884.*)

NO. II.—THE PHYSIOLOGICAL AND CLINICAL ASPECTS OF THE BILE SALTS IN THE URINE.

IN *hæmoglobinuria* the blood-corpuscles undergo rapid and wholesale solution, and the liberated hæmoglobin dialyses into the urine. Since I began to use the peptone test I have only examined the urine of one case of this interesting ailment—interesting specially from the pathological relationship which it suggests between a suddenly induced hepatic or portal disorder, flooding the blood with the central component of the bile, and the rapid hæmolysis. I am indebted to Dr. Tyson of Sheffield for sending me the sample to which I refer, and which enables me to demonstrate what I, and probably others, have long suspected—namely, the presence of a large quantity of bile salts in the urine of hæmoglobinuria. This is the specimen, a good example of the urine provided by this curious disease. The quantity at my disposal being very small, I dilute it to the specific gravity of 1008, and I obtain a deep blood-coloured solution. On dropping a citric acid test-paper into sixty minims of this diluted urine, a dense zone of precipitated proteid soon forms across the middle of the column, the portion of the urine below it remaining quite clear. Those of you who were present when I read my former paper will call to mind that I pointed out that when this zonular precipitation takes place in urine of normal reaction[1] the presence of bile salts along with albumen or a proteid may be inferred. This urine is a good example of the fact, for the precipitate is very copious, though the urine is diluted fourfold. In order to obtain a notion of the amount of the bile salts by the peptone test in urine containing blood or the elements of blood, it is necessary to boil it (being at the same time careful not to add acetic or any acid either before or after the boiling), when the hæmoglobin and albumen coagulate, as in this example, into brown masses, and then to filter; this done, the diluted urine before us produces the standard opacity when only four minims are added to sixty minims of the test solution, so that I take it the bile salts are 1500 per cent. in excess. Furthermore, the boiled and filtered urine produces a good reaction with Pettenkofer's test, as you observe.[2] By the side of the tube showing Pettenkofer's

[1] The specimen under examination is acid. When the urine is alkaline, the zonular precipitate from a citric test-paper dropped into it may arise from an alkaline modification of albumen, as well as from albumen along with bile salts.

[2] Inasmuch as there are no trustworthy means by which the results obtained by any new test for bile salts may be checked (otherwise, I suppose, there would not exist the need for a new test at all), one must fall back on broken reeds. The tests introduced by Casali (oxidising agents, barium peroxide, stannous or antimonious chloride, along with sulphuric acid)

reaction, I place another showing the dense zone of precipitated peptone induced by the diluted urine on which the peptone test solution has been run. I can but refer to what the examination of one specimen of hæmoglobinuric urine suggests; whether or not the same observations can be made in other cases remains to be seen.

An important observation was made by Dr. George Harley respecting the albumen of hæmoglobinuria, which now, in this sample at least, receives explanation if bile salts are present as well as albumen. This observer remarked that the albumen was readily dissolved by a slight excess of acid,[3] and that is so in the urine before us. The fact is indeed shown by the zone which appears on dropping into the diluted urine a citric test-paper, the excess of acid at the bottom of the tube preventing the appearance of the precipitate there. The following observation of Dr. Wickham Legg is also very important in connexion with the presence of bile salts in hæmoglobinuric urine; the urine of a gentleman who had an attack while under examination was immediately put under the microscope, when, says Dr. Legg, "there was no difficulty in recognising many red blood-corpuscles. The urine was set aside till the next day, when it was again examined. This time I could not discover a single corpuscle."[4] Other observers have likewise detected the same fact, and if you place under the microscope a drop of blood along with a solution of bile salts you will witness what in all probability takes place in hæmoglobinuria, either before the urine is voided (for there are cases in which not a blood-disc can be detected in the freshly discharged urine) or after its emission.

I have already referred to the effects of catching cold in increasing the normal discharge of urinary bile salts. Is the hæmoglobinuric patient, because of some curious susceptibility to chilling, an example of this fact on so large a scale that bile salts are let loose, as it were, from the portal organs into the systemic blood, so as to discharge the hæmoglobin from an immense number of the blood-discs? I have pointed out the association that appears to me to subsist between the increased urinary elimination of bile salts and ague, as well as the diseases of that organ of ever-varying capacities—the spleen; and I am inclined to view these observations as at least interesting, if not suggestive, when studied by the side of the symptoms and pathogeny of hæmoglobinuria.[5]

(*b*) *Scurvy.*—In the four cases examined there was a large excess. I show you the urines of two convalescent cases of scurvy which I lately saw at the Seamen's Hospital, Greenwich; they both contain over 200 per cent. increase of bile salts.

Capillary hæmorrhage is also a prominent feature of the cholæmia of jaundice, leucocythæmia, diseases of the liver and spleen, and of fevers—at the onset especially. The epistaxis of hepatic disease, and of cardiac disease inducing congestion of the liver and spleen, will doubtless occur to your minds as a probable example of a cholæmic hæmorrhage. May not cholæmia be sometimes a determining cause of cerebral hæmorrhage—as perhaps especially in those cases in which apoplexy follows an unusually hearty meal? In animals which succumb to the intravenous or subcutaneous injection of bile salts the blood is found imperfectly clotted. This defect in the coagulability of the blood of the cholæmic—a fact which has frequently been recorded post mortem—suggests an explanation of the liability to alarming and persistent hæmorrhages which these patients not unfrequently exhibit after some trifling operation, such as the extraction of a tooth; and furthermore, may it not be a factor in some cases of menorrhagia and flooding?

7. *Cardiac asthenia.*—The biliary salts greatly reduce the force of the heart's action, and the frequency also, if the patient is fever free, or there is no cause of reflex irritation present. The fact is sometimes well illustrated by the slow and feeble pulse of jaundice. But my observation leads me to view the depressed cardiac action of cholæmia as not only of pathogenic interest, but of some practical importance under special circumstances—such as the administration of anæsthetics. At any rate, this appears to be the teaching of a late well-attested experience. An anæmic patient, about twenty-five years of age, whose urine had contained during the preceding three months from 100 to 150 per cent. increase of bile salts, went to her dentist in Leeds, without consulting me as to the advisability of inhaling an anæsthetic: and the dentist wrote me as follows: "Leeds, April 14th, 1885.—I have just had Miss X——, a patient of yours, with me, to have a lower molar tooth and an upper bicuspid root removed under nitrous oxide gas. I have administered it to her before, with the usual results. To-day all went well until I was just on the point of operating, when the breathing suddenly stopped and she collapsed. By a prompt use of the ordinary means of restoration she recovered, and after half an hour's rest did not appear anything much the worse, except that she continued to feel faint." It is surely worth while to keep such a fact as this in mind. In this case there were no signs of recognisable organic disease of the heart or other organs.

II. *The urinary elimination of bile salts is insufficient.*—Hitherto I have spoke of an excess of bile salts in the urine: I now come to consider the possible, if not probable, condition implying retention of these elements in the blood from imperfect evacuation of them by the excretory channels—kidneys, bowels, and skin. To decide this question demands a much larger experience than mine, and the accumulation of a multitude of carefully recorded facts, such as are not at present at my command. Hence every position that I advance I look upon as merely suggesting either a standpoint or a point of departure for further observation. I would divide the cases into two classes—namely, those in which the bile salts are present in great excess in the blood and the elimination of them by the kidneys is checked or rendered defective; and those in which the production of them is not excessive, but the renal discharge is subnormal. In all there must be a persistent and increasing retention of these excrementitious matters in the blood; perhaps only now and then relieved by the vicarious efforts of the bowels or skin, or by an occasional spurt, as it were, of the kidneys.

The production is increased but the elimination is inefficient.—When the systemic blood is greatly surcharged with bile salts—as in fever, jaundice, and certain forms of anæmia,—the patient, it would seem, is as a rule safe from acute poisoning so long as the kidneys discharge them with freedom. It is true he suffers all the while from the textural degenerations induced by the presence of them in excess in the blood; but while the charge of them is kept down below a certain dose, as it were, by efficient elimination, he runs no risk of imminent danger. It is otherwise when the kidneys and the other emunctories fail to bale out the pernicious material; for then it accumulates and effects further destruction of the cellular elements, and may even reach that percentage proportion which experiment has shown will induce convulsions and coma—a catastrophe which may, however, be averted for a time by a vicarious evacuation from the bowels or the skin, or perhaps by bloodletting. In high fever, especially at the onset in children, this is by no means an uncommon event;[6] and it is possible that now and then a fever patient has been sacrificed by the injudicious checking of a critical or vicarious evacuation. It is likewise occasionally met with in jaundice; when the patient unaccountably becomes apparently uræmic, or at any rate he is seized with convulsions and dies comatose. It is, therefore, of some practical importance, whenever there is a large proportion of bile salts in the blood—as, for example, in fever and jaundice—to see that the renal elimination of these noxious constituents is sufficiently free; and when a decided falling off takes place, while the fever is high or the jaundice is unabated, the observer should be ready to assist evacuation by other channels, and should be on his guard not to check a salutary discharge.

In chronic cholæmia my experience inclines me to think

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have proved worthless in my hands for urinary observation; and the evidence of Pettenkofer can only be taken for what it is worth, for it is easy to prove that it reacts with albumen. But my observation on the reactions provided by albumen and by bile salts with Pettenkofer's test has led me to recognise a difference, the purple zone of albumen appearing at once either at or more generally just above the line of contact of the urine with the sulphuric acid, and freely diffusing itself upwards into the urine, while the colour reaction with bile salts requires time, is rarely immediate, and appears in the upper layer of the sulphuric acid, there often appearing a clear space between the zone and the urine. A point of great practical importance in using Pettenkofer's test is to prevent charring by inserting the tube at once into cold water after running down the sulphuric acid.

[3] Med.-Chir. Trans., vol. xlviii., p. 170.

[4] On Paroxysmal Hæmoglobinuria, St. Barth. Hosp. Rep., 1874, p. 77.

[5] I am inclined to think that hæmoglobin is present in the cold infusion of the splenic pulp. The elasticity and contractility of the envelope of the spleen, its amenability to reflex contraction, and its capacity of dilating to a large size, are, I think, important physiological facts to be duly weighed in our reasonings about hæmoglobinuria. (See Addendum.)

[6] The reader will bear in mind that in children under six years of age the liver weighs more in proportion to the body weight than obtains in after years.

that a check to the renal elimination of the bile salts may lead to retinal or other hæmorrhages, or to some similar results of the toxæmia. For example, an anæmic girl who for some months had been discharging a considerable excess of bile salts by the kidneys, one day complained of some curious sensations about the left eye, when I found the renal discharge of the biliary elements had gone down to nearly the normal amount. Suspecting that a retinal hæmorrhage had taken place, I sent the patient to Dr. Hartley of Leeds for his independent report, which amply confirmed my suspicion.

(To be continued.)

ONE HUNDRED CASES OF VARICOCELE TREATED BY THE SUBCUTANEOUS WIRE LOOP.

BY RICHARD BARWELL, F.R.C.S.,
SURGEON TO CHARING-CROSS HOSPITAL.

ON the 10th ult., two lads, Henry B——, aged seventeen, and John J——, aged sixteen, came under my care for the cure of varicocele, which had caused their rejection by the examining officers of Her Majesty's navy. On April 16th I performed on these lads the operation which I introduced some years ago—viz., that of passing subcutaneously round the veins a wire loop, which, being tightened every other day, first occludes and then slowly cuts through them. In the case of Henry B——, this process was completed and the wire came away on the thirteenth day; in the case of John J——, on the fifteenth day. In neither case was there any suppuration or swelling, and only momentary pain at the times of tightening the wires. I have already described the method of operating,[1] and shall therefore on the present occasion give a very brief account of the procedure, the object of this communication being to analyse the results of 100 operations which I have now performed.

The only instruments required are a needle armed with about ten inches of silver wire, gauge twenty-six, or even a little less; a pair of pliers, and an oval shield of vulcanite, one-eighth of an inch thick, with a long diameter of an inch, a short one of about three-quarters of an inch. Near each end is a brass upright, projecting a quarter of an inch. Close to the spots where these uprights are fixed the shield is perforated by oblique channels which open on the other side near the centre. The surgeon must very carefully separate all the veins from the vas deferens, and squeezing together between his left thumb and index the two sides of the scrotum, he keeps the duct and the spermatic artery behind and the veins in front. He then thrusts the armed needle through that half of the scrotum from without inwards, thus placing the silver wire between the above-named parts; he then reintroduces the needle at the previous hole of exit, and when its point lies within the scrotal cavity he relaxes his grasp on that part, and partly by passing the needle onward, partly by manipulating the veins behind its point, he brings the original opening of entry towards it and extrudes the needle. It is only necessary to be sure that no veins escape, and that no part of the lining fascia of the scrotal cavity is included. When these manipulations are completed the veins are encircled by a loop of wire, the ends of which hang out of one puncture at the outer side of the sac. These ends are passed each through one of the holes in the shield, and when drawn sufficiently tight are secured by twisting them round the uprights. It is well, however, to place three or four folds of lint—or better still, a piece of felt, in which a slit has been cut—between the shield and the skin. Every other day the wire must be unwound from one of the uprights,[2] tightened, and replaced. Thus it acts as a very slow écraseur and cuts through the veins in some time between eight and sixteen days, according to the bulk of the varicocele.

Of the 100 cases operated on by me in hospital and private practice I have kept notes; their analysis is as follows:—In no case was there any bleeding, shivering, pyrexia, erysipelas, or other disquieting manifestation. In 16 there was slight suppuration; in 15 of these the pus found its way out along the wires, and gave rise to no trouble; in 1 a little abscess formed in the thickness of the scrotum and was evacuated by an incision one-third of an inch long. In 12 there was a little ulceration where the shield pressed against the skin; it healed when the wire came away. In 1 there was some orchitis, which lasted five days. In 71 there were none even of these trifling complications, the course of events being precisely like that of the cases above recorded. Three patients would not submit to be confined, but walked out after the second day; one of these belonged to the class in which some suppuration occurred, the other two to that in which no complication took place.

The above may be termed the immediate effects of the operation. There remain still to be considered the remote or ultimate result, and therewith the conditions previous to operation.

A (1 case)—Testicle only represented by a small pultaceous mass; the bunch of veins considerable, larger than the gland. (Patient aged twenty-seven.)

B (13 cases).—Testicle very soft and small.

C (47 cases).—Testicle much diminished and of considerable softness.

D (32 cases).—Testicle somewhat diminished and soft.

E (7 cases).—Slight varicocele operated on for the sake of passing examination.

In the first four categories, chiefly in the second, third, and fourth, the organ was the seat of more or less pain; in 23 cases this was severe.

A.—The pain ceased, and the testicle became both a little harder and larger; the patient thought it regained some function. He married five months after the operation, and is the father of four children.

B, C, D.—In every case the testicle became harder, and regained some of its dimensions immediately after the operation, but did not entirely resume its natural consistence and size until after a considerable time: in some of the worst cases, so far as I was able to trace, being as much as two years; in others, and more especially in the younger patients, three months.

E.—The slight cases under this heading passed the examining board very soon after operation.

I lost sight of most of my 100 cases within a few months of operation, chiefly hospital patients, some of whom I never saw again after their discharge. One case (*A*) I even now see occasionally, nineteen years and a half after operation. The left testicle is still smaller and softer than normal; the right one is healthy, and unusually large. Of the 92 belonging to classes *B, C*, and *D*, I have only seen 28 at an interval of more than six months after operation. In all of these, except 2, whose testicles were still somewhat soft,[3] a perfectly normal condition existed. One of these cases, a gentleman who had been married fifteen months, had a rather large varicocele; the testicle was very slightly softened; but he had almost constant pain in it, and after coitus this was so increased that he described it as agony. After operation the pain subsided considerably, and in seven weeks had entirely disappeared, nor did it recur. I kept this patient under observation for twenty-seven months. Three others (not included with the above 28) contracted gonorrhœa and one syphilis. Of the former, one had orchitis of the left (very slight) and one of the right testicle. The gentleman who contracted syphilis neglected himself, and remained deeply affected for nineteen months. Since that time he has remained free from any manifestation, except occasionally ulcerated fissures at the side of the tongue.

This is all the information I can give concerning the 100 operations. The safety and efficacy of the procedure are, I think, fairly attested by these results. The very slight degree of pain, either at the time or afterwards, should also be mentioned. I have operated on five cases without any anæsthetic.

George-street, Hanover-square, W.

[1] THE LANCET, vol. i., 1869, p. 711; also vol. i., 1875, p. 820.

[2] I have lately modified twisting the wire round the upright, and now fix it by means of a binding screw.

[3] At from six to eight and eight and a half months respectively after operation.

THE agitation and controversy which have for several months existed between the Canterbury Corporation and the owners of some sixty private wells, the supplies from which were condemned as polluted and unfit for drinking purposes, are at length reported to have almost settled down.

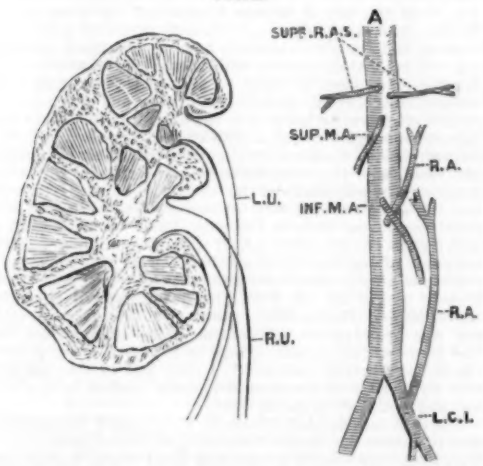
REMARKS ON TWO CASES OF SINGLE KIDNEY.

BY P. W. MACDONALD, M.B. & C.M. ABERD.,
DEPUTY MEDICAL SUPERINTENDENT, DORSET COUNTY ASYLUM.

CASES of congenital absence of one kidney are comparatively rare. Mr. Henry Morris, in an address before the Medical Society of London, said:—"Out of 8068 post-mortem cases there were but two instances of congenital absence, and one only of congenital atrophy, of the kidney."[1] To have met with two cases in less than one hundred necropsies has, judging from recorded cases, been the experience of none, and I have thought the following remarks might be of interest to those who give their special attention to the surgery of the kidneys.

The first case I met with was in 1881. The subject was a male patient suffering from epileptic dementia. He died on April 27th, and a necropsy was made forty-eight hours after death. The brain, lungs, and heart were found to be, as far as the naked eye could discern, normal. Liver large and congested; capsule adherent. Cut surface shiny and dark-coloured; blood oozed out; whole organ soft and

FIG. 1.

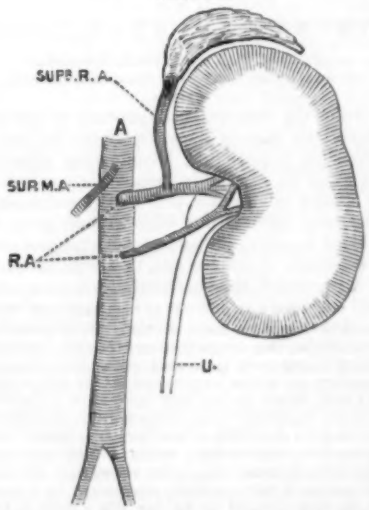


probably fatty. Spleen normal. The liver and spleen being removed, I then proceeded to remove the kidneys, and found they were absent from where they normally ought to have been. Reflecting the mesentery and small intestines, one large kidney was found lying on the spinal column opposite the second, third, and fourth lumbar vertebræ. (Fig. 1.) It was enveloped in a natural capsule. It was large, weighing over 11½ oz., and somewhat irregularly shaped. Vascular supply abnormal and large. One branch had its origin from the aorta, and a second one from the left common iliac artery. The branch from the iliac artery, which was the larger, entered at the normal pelvis, and the one from the aorta at the second or smaller pelvis. There were two ureters. One came from the normal pelvis of the kidney, the other from a sort of second pelvis at the upper end of the kidney. Both entered the bladder normally. The one from the smaller pelvis passed behind the one from the normal pelvis, and entered the bladder on the right side (as right ureter). The other ducts and glands in connexion with the prostate were normal. There were two supra-renal capsules, one situated on each side of the eleventh dorsal vertebra, therefore quite unconnected with the kidney. Pelvic organs normal.

The second case was that of a female patient, who was admitted into this asylum on Aug. 16th, 1883, and died on Dec. 3rd, 1883. This patient was also the subject of epilepsy. At the necropsy, made twenty-four hours after death, the body was emaciated, and there was slight œdema of the left leg. Head: Thickening and opacity of the arachnoid over the frontal lobes and atrophy of the left superior frontal convolution. Pia mater easily removed. No apparent congestion. Heart large, and muscular structure pale; valves closed. Both lungs were studded with caseous nodules, and there were several rather large cavities in the left lung. There were pleuritic adhesions. The liver was soft and pale. On section, there were signs of commencing fatty changes. The capsule showed whitish patches. The spleen was normal. Intestines normal and no ulceration. On proceeding to remove the kidneys, no trace of the right kidney or ureter could be found. The left lay in its normal position; was large, weighing over nine ounces. (Fig. 2.) The suprarenal capsules were normal. There was one ordinary-sized ureter, which entered the bladder on the left side. There were two renal arteries; one large one coming off from the aorta below the superior mesenteric artery, and a second smaller one an inch below the larger. The larger one gave a branch to the left supra-renal capsule. The right capsule received a branch from the aorta. The kidney was congested, but not otherwise diseased. Pelvic organs normal.

In neither case was it known during life that there was only one kidney present—a fact easily understood when it is stated that in the first case the patient was an epileptic dement, and at no time of his residence in the asylum had he shown any symptom of kidney mischief, and at last died from

FIG. 2.



general decay. The subject of the second case (female) was also suffering from epilepsy with maniacal symptoms, and after a short residence in the asylum succumbed to one of the most dire diseases, phthisis. The œdema of the left leg in this case was due to an enfeebled and embarrassed circulation. It will thus be seen that there was at no time any necessity to make an external examination of the kidneys, and consequently the fact remained unknown till met with on the post-mortem table. The interesting points are the abnormal site of the kidney with its two ureters, in one case, and the large and abnormal arterial supply in both. There would have been much difficulty in arriving at even a probable diagnosis as to the site of the kidney, in the first case, had need arisen to map out the kidney on the living subject, a proceeding which is at no time attended with certainty; for Mr. Luther Holden says: "I have never succeeded in satisfying myself that I have distinctly felt its rounded lower border in the living subject, nor even in the dead."[2] As already mentioned, the kidney was large and irregular. On section it seemed to be one large kidney with a smaller one joined on to its upper end. The smaller pelvis had separate and distinct pyramids, and there was a rather thick cortical layer between them and those of the larger or normal pelvis. The arterial supply was abnormal in both cases, and the branch supplied by the left

[1] British Medical Journal, vol. i., 1885, p. 134.

[2] Landmarks, Medical and Surgical, p. 38.

common iliac artery would have caused much annoyance in any operation on that artery or in its immediate neighbourhood.

Numerous cases of the congenital absence of one kidney have been met with and reported. Mr. Jonathan Hutchinson, in a clinical lecture[3] delivered at the London Hospital, mentions a case and draws attention to the dangers that may arise in such cases from suppression of urine by renal calculi or any other untoward event. Mr. Gubbin[4] reports a case of complete absence of the left kidney and suprarenal capsule, and quotes a series of cases collected by Dr. Brenner in 1858.[5] Dr. Brenner states that in a third of his cases there was malformation or arrest of development in one or other of the genital organs. Mr. Thomas Wilmot[6] mentions a case of single kidney, and states that the apparent cause of death was the secondary formation of an abscess in the kidney. In 1878 Beumer collected a series of cases, and drew attention to the effect of the absence of one kidney on the sexual passions. In the literature on the subject to which I have had access I fail to find a reported case of single kidney with two ureters. Notwithstanding that such cases are rare, it is, nevertheless, necessary in these days of advanced abdominal surgery to recall and bear in mind such important abnormalities, for a timely thought in this direction might save both surgeon and patient from unpleasant recollections.

Dorset County Asylum.

ON AURAL EXOSTOSES.

By GEORGE P. FIELD, M.R.C.S.,
AURAL SURGEON TO ST. MARY'S HOSPITAL.

THE following four cases of exostosis in the auditory canal have been recently under treatment by me. I now place them on record—first, because they afford further demonstration of certain important facts which I have already insisted on—namely, that ivory aural exostoses can be successfully removed, not only without great risk, but with decided benefit to the patient, relieving him sometimes of grave cerebral symptoms, and, as a rule, completely restoring the power of hearing; secondly, because I find that it is still customary to inform persons afflicted with these growths that they must make up their minds to endure permanent deafness, the dangers of any possible operation for their relief being such as to render it entirely unadvisable. How contrary to actual experience is this latter statement has been well shown by my first case, that of Dr. G. M—— of Waterford, operated on in October, 1877, and described in THE LANCET for July 20th of the following year. As I have there remarked, the patient, when I first saw him, was suffering from extreme depression of spirits; for, knowing each of his ears to be completely obstructed by a dense bony tumour, he felt himself to be for life debarred from the pleasures of society. The result of operation in his case was thorough restoration of hearing, which now, after the lapse of eight years, remains as good as ever.

The origin of ivory aural exostoses has been repeatedly attributed to gout, rheumatism, or syphilis, alone or combined; but, as I first pointed out in the discussion of my earliest case, a certainly far more general cause is a chronic inflammation of the walls of the external meatus, such as might be produced by habitual sea-bathing. The Hawaiian islanders, as readers of works of travel are aware, are practically amphibious; and Professor Wyman has directed attention to the significant frequency of ivory exostoses in the external auditory meatus of their crania. The four cases that I have operated on during the past three months, I have been interested to find, afford evidence of one and the same exciting cause—persistent sea-bathing. A former opinion of mine, that hereditary predisposition might be excluded from the probable sources of ivory aural exostoses, I have had occasion to modify to some extent; for one of my most recent patients is a younger brother of my first case, and suffered in an exactly similar way from exostoses in both ears, though happily, unlike him, requiring only one operation for their extirpation, instead of repeated treatment occupying altogether seven hours; it must, however, be noted, that both patients had for years been accustomed to bathing in the sea three or four times a day. In hospital practice I have, as others, remarked, the absence of instances of ivory aural exostosis, whereas the softer growths are not infrequent. Seemingly another peculiar feature in connexion with the disease is that in certain districts it is commoner than in others. Thus, I have had four cases from Waterford, three from Ipswich, several from the south of Ireland, and one each from Hull and West Hartlepool, &c. The operation of drilling the tumours with the American dental engine, as first suggested by Dr. Arthur Mathewson of New York, I have more than once described.[1] For further information as regards the varieties, mode of occurrence, and characteristics of osseous tumours of the meatus, I would refer to the third edition of my book, p. 69.

I will now proceed to give, as briefly as possible, an account of my four most recent cases.

The first is that of Mr. W. G. D. G——, aged forty-six, a gentleman living near Waterford, whose history I do not think I can do better than give in his own words, as follows: "I was first troubled by an abscess in my right ear in Sept. 1883, the effect, probably, of sea-bathing, and the frequent use of an old spring-board some beggar put up on Kelly's Rocks, evidently for the benefit of the medical profession. The abscess caused deafness for some three or four weeks, but was eventually cured by the application by Dr. O'Farrell of a solution of caustic. In October, not being satisfied with the feel of my ear, I consulted Mr. Fitzgerald in Dublin, who said the passages in both ears were much contracted, and I might eventually have to get them operated on. He prescribed a lotion, which I used for some time, and hearing came back all right. In 1884 I was yachting from the middle of May till the end of September, and took a header or two off the main boom each morning. At the end of the season I was again troubled with an abscess, this time in the left ear, causing deafness. At the end of November I consulted Mr. Field, who diagnosed double ivory exostosis. After the removal of a polypus from the left ear its hearing returned; but the exostoses had now so increased that, as soon as I could spare time, early in February, I had the worse ear, the left, drilled, the operation lasting sixty-five minutes. In consequence of leaving London before the ear was sufficiently healed, it became filled with granulations, which gave much trouble to get rid of from the beginning till near the end of March. On the 9th of that month the other, or right, ear was operated on, chloroform being administered for one hour and ten minutes, and in it also hearing is now (April 11th) nearly restored." I may add to this account that by April 25th audition was quite perfect in the left ear, and well nigh so in the right.

The next case is that of Mr. S. W——, aged twenty-six, sent to consult me by Mr. Swannick, of West Hartlepool, in Nov. 1883. He was then suffering from slight deafness of both ears, caused by the presence of exostoses, which I suggested should be removed if they gave rise to any further trouble. When, in Feb. 1885, he came back to me, I found the left external meatus considerably lessened in calibre, and the right almost completely blocked by the exostoses. I had now no hesitation in recommending early extirpation of the growths. On Feb. 24th, chloroform having been administered, I succeeded, after fifty minutes' labour, in effectually drilling through the obstruction in the right ear. The patient recovered well from the operation, and had one or two returns of his nocturnal giddiness during the next few days. My colleague, Dr. Broadbent, who saw him, kindly gave me the following opinion of his case:—"Mr. S. W——'s attacks may be conveniently called epileptiform, but they have not the character of epilepsy proper, inasmuch as there appears to be neither convulsion nor loss of consciousness. I am disposed to fear that they differ in a more important respect, and that they are attended with danger to life. I do not think, however, that, like some of the cases recently reported, the attacks are due to the slow pulse with which they are accompanied. In my opinion they are cerebral in origin, and the retardation of the pulse is secondary. I did not find much on examination which threw light on the case. The optic discs were small and pink and without sharp outlines; and the retinal veins were large; but there was no neuritis. The right temporal artery was more conspicuous than the left, and pulsation

[3] THE LANCET, vol. ii., 1874, p. 1.
[4] British Medical Journal, vol. i., 1883, p. 115.
[5] Virchow's Archiv.
[6] British Medical Journal, vol. ii., 1883, p. 1014.

[1] See THE LANCET, July 20th, 1880, and April 1st, 1882; British Medical Journal, Nov. 24th, 1883; also see Roosa's work, sixth edition, p. 485.

was visible in it. It is quite possible that the attacks may have been due to the exostosis which you have removed, especially if secretion had accumulated behind it; but time alone can decide this. The case puts me strongly in mind of one that I saw many years since. The attacks, one of which I witnessed, corresponded closely with the description given by Mr. S. W——, and the intellect was unimpaired to the last. The patient died in an attack, and on examination there was found tremendous thickening of the frontal bone. In any circumstances it was right to remove the exostosis; and I shall be greatly interested in the result." The result was so far satisfactory that the hearing became quite restored in the ear operated on, and the patient, after a month's absence, went home apparently quite well. On the 29th of April Mr. Swannick wrote to me as follows:—"Since his return he has had a few fits, one of which, at evening service on Sunday, was severe. From that date till now I have been giving him bromide of potassium three times a day, and he has had only one slight attack. The gloominess and depression that come on every evening at about 7 o'clock are diminishing, and he feels altogether happier. The only question that now arises is whether the second ear (the left), which is almost closed, should be operated on."

The next case, that of Dr. W. L. M—— of Waterford, brother of Dr. G. M——, operated on eight years ago, as above mentioned, is thus described by the patient himself:—"W. L. M——, a medical man, aged thirty-five, strong and healthy, has been all his life a great sea-bather. He has never had syphilis. In August, 1884, he first began to experience a disagreeable 'fulness' in the ears, most marked in the left; unaccompanied, however, by either pain or deafness. Thinking this was probably caused by the presence of wax, on Aug. 19th he syringed out the left ear with warm water, rendering it immediately very deaf. As during the next few days hearing was not recovered, he became uneasy; and on the 22nd he consulted Dr. Storey in Dublin, who diagnosed a large exostosis in each ear, with irritation and inflammation of the left meatus. A solution of nitrate of silver (ten grains to the ounce) having been applied daily, the patient on the evening of the 28th recovered his hearing. Mr. Field, whom he saw in London on Sept. 22nd, confirmed Mr. Storey's diagnosis. The exostoses were then both of considerable size, that in the right ear being the larger; but as there was still ample room for the passage of sound, Mr. Field recommended him to report himself at intervals, so that the progress of the disease might be observed. For the next few weeks no inconvenience whatever was experienced. On Oct. 23rd, when Mr. Field was again consulted, there was evident, but still only very little, enlargement of the right exostosis, while that of the left was scarcely perceptible. On the occasion, however, of the next visit, on March 12th, 1885, although hearing had in the interval continued perfect, and no distress or pain had been suffered, Mr. Field advised an operation without further delay, both exostoses having increased so much that an extremely constricted space remained for the admission of sound. The patient accordingly went home, and, having made the necessary arrangements for remaining in London, returned thither on March 24th. On the same day Mr. Field operated on both ears. The exhibition of chloroform, which lasted fifty-five minutes, was not followed by any sickness, pain, sleeplessness, or lack of appetite. There was, however, great deafness, and on the day after the operation healthy pus was discharged from both ears. On March 27th the patient was able to be up, and on the 30th he called on Mr. Field in his own house. On April 16th whilst still very deaf he removed from London. On the day following the left meatus cleared up sufficiently to admit of distinct hearing for about three hours, the right improving in a less degree. During the next fortnight hearing was very variable, being sometimes perfect with the left ear for hours, at other times absent for days together." On the return of the writer of the above from Ireland, on May 8th, to see me again, I found the ears still somewhat swollen but presenting plenty of room for the passage of sound. The curious feature in this case is its exact resemblance in symptoms and in the gradual recovery of hearing by both ears to that of the brother, Dr. G. M——, already alluded to.

My next instance of removal of aural exostosis is afforded by Mr. H. C. W—— of Ipswich, aged twenty-five, who has furnished me with the subjoined account of himself previous to the operation:—"It was in May, 1881, that I first felt inconvenience in hearing, but my deafness, which was not total, passed off in some four weeks. In January, 1882, I gradually lost all use of my right ear; and during the end of February and early part of March I had much pain in it, which my doctor could not relieve. On the 28th of last month I called on Mr. Field, who told me the ear would require an operation. He gave me a lotion which almost immediately relieved my pain, and after applying this thrice a day for some three months my hearing returned. Subsequently, until December, 1884, I was able to hear perfectly, although conscious of something in the ear which prevented one from pulling it about with impunity. In that month I grew quite deaf; and in March, 1885, I began once more to suffer pain, which was very acute. When, on April 13th, I for the second time consulted Mr. Field, he pronounced an operation absolutely necessary, and this, on the 21st, was performed." It remains to be added that in this case the growth was very large, and, after the use of the drill, had to be broken up with bone forceps,[2] in a manner similar to that described in THE LANCET, April 1st, 1882. The patient recovered well from the operation, which lasted sixty-five minutes. His hearing is now (May 10th) almost perfect, and in a few days he will return home.

A consideration of the above and other cases leads one to the following general conclusions with respect to ivory aural exostoses:—1. They are by no means necessarily associated with a rheumatic, gouty, or syphilitic diathesis. 2. Their causation can, with strong probability, be ascribed in many, if not in all, cases to some local irritation of the external auditory meatus, such as may be set up by habitual sea-bathing. 3. They can be most efficiently treated only by drilling, which with proper precautions—notably the use of a pliant and not brittle steel guard to protect the ear in the event of slipping of the drill—is a perfectly safe operation. 4. Their prompt removal is indicated in all cases where (*a*) they hinder the elimination of secretions and discharges from the auditory canal; (*b*) where they occasion pain by pressure on neighbouring structure; (*c*) where they threaten completely to block the meatus, and so to deprive the patient partially or wholly of hearing.

Lower Seymour-street, W.

THE BULLÆ OF PEMPHIGUS.

BY GEORGE THIN, M.D.

IT has been stated by Gibier[1] that acute pemphigus is due to a parasite. The microbe of acute pemphigus, according to this author, presents a beaded appearance when fully developed, the elements being grouped in rows consisting of two to twenty joints. Development takes place from minute spherical bodies isolated or irregularly grouped, or contained in zoogloea. This organism was found in the liquid of the bullæ, and in the urine of the patient who formed the subject of his investigation. In the liquid of the bullæ in a case of chronic pemphigus the same author found a few bacteria moving slowly (*rares bactéries à mouvements lents*).

In a well-marked case of pemphigus in which I have recently examined the fluid of the bullæ I was unable to discover any organism.

A tall strong man, aged fifty-two, who had always enjoyed good health, consulted me on February 3rd, 1885, on account of an eruption. He stated that two months previously he had a rigor, and that within the next two or three days several "bladders" appeared on his forehead. Others then came out on his chest, arms, and legs, and had continued to appear more or less ever since. I found his face, neck, temples, and ears the seats of a bullous eruption, which in the aggregate involved on the lower part on the face more than half the surface. There were also several bullæ on the chest, back, arms, and legs, some being full of clear serum, some collapsed, and some burst, leaving a red moist surface covered with folds of epidermis. His general health was

[2] This was one of those cases which may be dealt with by the use of a chisel and hammer, or, as I prefer, by bone forceps, for the exostosis was not so hard as in the three cases just described. A large quantity of bone was removed from this patient's ear, and the external auditory meatus afterwards looked large and open. The chisel I believe to be absolutely useless for ivory exostoses, and nothing but the drill, which makes only a small orifice (quite sufficient for the passage of sound), is of any service.

[1] Annales de Dermatologie et de Syphilographie, vol. iii., p. 102.

not perceptibly impaired. Fresh bullæ continued to come out, and I had an opportunity of observing them in the earliest stage from their first appearance as minute, scarcely raised, vesicles, not much larger than a pin's head, with a central depression, and as large bullæ about two inches long, three-quarters of an inch broad, and about half an inch high.

On three separate occasions I examined the fluid of the bullæ microscopically without observing any organisms. I also prepared a number of cover glasses, on which the fluid was dried in the now familiar way, and the glasses, after being heated, were floated on solutions of aniline dyes and properly prepared for examination. No organisms were stained. In one preparation, examined fresh with the addition of a solution of gentian violet, some epidermic cells were found in the fluid, and to one of these micrococci were found adherent. The results of examining the fluid of the bullæ, both fresh and after being dried and stained, were thus, so far as organisms are concerned, entirely negative. A few white blood-corpuscles were found in the fluid. On Feb. 6th and 10th attempts were made to cultivate any organisms that might be present. The bullæ were opened largely with a purified lancet. A pure platinum wire was plunged into the depths of the bullæ, and tubes of sterilised gelatine-peptone meat infusion inoculated in the usual way. Two neutral, two alkaline, and one acid tube were thus inoculated and put aside at the ordinary temperature of my laboratory. Up to April 13th nothing had grown in the tubes, the gelatinised meat infusion having in the meantime become considerably shrunk.

These observations do not prove that no organisms are present in the fluid of the bullæ of chronic pemphigus, but they tend to show that typical pemphigus may exist without the presence in the bullæ of organisms which can be put in evidence by the methods on which reliance is now placed. The organisms described by M. Gibier could not have been present in my case.

Queen Anne-street, W.

A CASE OF LUMBAR COLOTOMY.

BY WILLIAM DOBBIN, M.A., M.D., &c.,
MEDICAL OFFICER, BANBRIDGE DISPENSARY.

ON March 24th, 1884, I visited a dispensary patient, Elizabeth L——, aged seventy, married, residing at Tullyrain, near Banbridge. She was a tall woman, emaciated and cachectic-looking, but was not confined to bed. She stated that she was troubled with piles, and had suffered from painful defecation, attended with a bloody discharge, for nearly three years. Lately her condition had become much aggravated as the constipation was more difficult to overcome, and there was much distressing tenesmus. On examination I found that there was a small tumour of stony hardness at the posterior margin of the anus, which doubtless had been formerly a pile, but was now a mass of scirrhus. The sphincter was a rigid circle which would admit only the tip of the finger, the introduction of which caused extreme distress. Per vaginam I found that a hard nodulated mass extended upwards for some four inches, projecting into the vagina in front and apparently encircling the lower end of the rectum. Avoiding mention of the dreaded word cancer, I told the patient that the only mode of relief was by an operation, but that it might be delayed for some time if she were careful to keep the stools soft by castor oil. An occasional opiate was administered when the pain was very severe, and I kept her under observation, visiting her from time to time when in the neighbourhood.

Matters went on without much marked change for nearly four months, when, on the 17th of July, I received a message saying that she could not bear her condition any longer, and that she would submit to any operation for relief. As soon as possible I proceeded to her house accompanied by Dr. Smyth, J.P., and Dr. Tweedie of Banbridge, who kindly afforded me their valuable advice and assistance. They concurred in the diagnosis of malignant stricture of the rectum, and agreed that lumbar colotomy ought to be performed at once. Chloroform having been administered, the colon was opened in the left loin by Callisen's operation as modified by Mr. Bryant, all of whose directions in the various steps of the operation were carefully followed. Hardly a tablespoonful of blood was lost. Some difficulty was experienced in seizing the gut, as rather unexpectedly it was found to be empty. After the sutures were fastened the part was dressed with carbolised oil on lint, a pad of oakum was applied, and the whole secured by a binder. Ordered to have milk diet for a few days, and fifteen minims of tincture of opium in half an ounce of water every four hours.

July 18th.—The patient has passed a good night, and feels very comfortable. Pulse 80; tongue clean; skin cool; no pain or tenderness. Wound dressed; looking healthy. Ordered five grains of compound ipecacuanha powder every four hours in place of the draught.—19th: Wound dressed. The patient feels very comfortable.—20th: Wound dressed. A good deal of flatus has passed through artificial anus, but no fæces. Flatulent distension complained of; a linseed-meal and mustard poultice to be applied to abdomen. In addition to anodyne powders, to have a grain of quinine three times a day.—21st: Wound dressed. Since last visit there has been a free discharge of semi-fluid fæces through artificial anus; abdomen much less distended; some appetite for food; in good spirits. Compound ipecacuanha powder to be discontinued, except five grains at bedtime.—22nd: Wound dressed; free discharge of fæces continues; sutures removed; most of skin wound healed by first intention; opening in bowel firmly united to skin.—23rd: Wound dressed. Discharge of fæces has been enormous since the middle of the night; a good many scybala have passed.—24th: Wound dressed. Since last visit fæces have passed in large quantity, but have now ceased. She is clean and comfortable, and is in good spirits.—25th: Since last visit a small quantity of fæces passed per vaginam. This happened only once.

On July 28th, during the night, the patient's husband, who alone lived in the house with her, died suddenly in the bed beside her; and the poor creature, being dreadfully frightened, made her way in a half-dressed state to the house of a relative, who lived about half a mile off, for the purpose of seeking assistance. Fortunately, the journey did her no injury, although she fell several times. After the fatigue passed away she made a capital recovery. A pad of fine tow was kept constantly over the artificial anus, and was fastened in position by a binder. A new pad was applied after each action of the bowels, which took place usually once in the twenty-four hours. Under these circumstances the woman's health continued fairly satisfactory till the end of October, when a large abscess formed and discharged in the left hip. From this period she gradually became weaker and more cachectic, and finally sank on Nov. 24th, four months and seven days after the operation.

Remarks.—Surgical interference without doubt prolonged the life of this patient. It not only relieved her from painful and exhausting straining efforts at defecation, but retarded the progress of her malady by preventing the irritating passage of the fæces over the diseased bowel. What is more important still, existence was rendered endurable and the woman was enabled to end her days in comparative comfort. After the first week she told me she was easier than she had been for two years, and that she was already more than compensated for submitting to the operation. Such a result is ample justification for operating, and I should have no hesitation in recommending colotomy in a similar case. The operation is not excessively difficult if Mr. Bryant's directions as given in his work on the Practice of Surgery are carefully attended to, and it is not more dangerous than herniotomy, if done in good time. There is no necessity for a patient the subject of artificial anus to wear any special appliance, since a pad of fine tow is quite sufficient. It is cleanly, cheap, and a fresh one can be put on whenever required. I have reported this case, occurring in the practice of a country surgeon, as it may encourage others similarly situated to carry out a serious operation even in the confined bedroom of a dispensary patient.

Banbridge, co. Down.

DR. G. E. PAGET.—At the next quarterly meeting of the governors of Addenbrooke's Hospital, the Lord-Lieutenant of the county will, on behalf of the governors, be asked to accept a bust of Dr. George Edward Paget, F.R.S., Regius Professor of Physic in the University of Cambridge, which has been provided by the subscriptions of a large number of persons, the list being headed by his Royal Highness the Prince of Wales and his Royal Highness Prince Edward of Wales.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas at morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

GUY'S HOSPITAL.

SURGICAL CASES UNDER THE CARE OF MR. BRYANT.

OF the following cases, the hernia, which was under the care of Mr. Bryant, is an example of an unusual condition of the hernial sac and position of the intestine, for which it is somewhat difficult to account without a history of taxis. The case described by Mr. Bond is uncommon. There is a similar condition illustrated in the article on Hernia in "Holmes's System of Surgery," vol. ii. The series of abdominal operations performed by Dr. Wallace are interesting and important.

CASE 1.—*Intra-parietal Strangulated Inguinal Hernia; Operation; Recovery.* (Reported by Mr. Rymer.)—Maria E——, aged fifty-three, was admitted into Lydia ward on Oct. 4th, 1884. The patient is healthy, and has had twelve children. She has had a slight rupture for years; it appeared after a strain. She kept her bed at first for about a week, and has worn a truss pretty regularly since. On the 3rd she neglected to put on the truss, and the rupture came down. She applied the truss, and the rupture appeared to go up, but she felt uncomfortable all day, and in the evening was sick. She did not sleep all night. Next morning she was sick again, and the vomit appeared fæcal.

On admission, when the patient was lying on her back in bed, no external signs of rupture were visible, but upon manipulation a tense swelling could be felt in the right inguinal region behind the abdominal muscles, above and external to the internal ring. The patient had another fæcal vomit. She was given chloroform, and an exploratory incision was made about an inch in length over the middle of Poupart's ligament, and one inch above it. The inguinal canal was laid open and the internal oblique and transverse muscles divided. When the sac was reached it appeared very much to resemble the tunica albuginea of the ovary. When this was opened a small quantity of bloodless fluid escaped. On careful examination this sac proved to be the old inguinal sac, hardened and thickened by the constant pressure of the truss. The finger was introduced and another large sac was felt. This sac was well slit up with a pair of scissors, and at one point there was a ring which admitted the finger into the peritoneal cavity. This ring was freely divided. Now the intestine could be seen, and was taken up and pushed back into the abdomen. The parts were put into apposition and held by three gut stitches, and the wound dressed with a pad of iodoform gauze and a sponge. This unusual appearance was seemingly caused by the constant pressure of the truss having broken down the band of the first sac and forced the intestine into a second sac, which was formed between the peritoneum and the iliac fascia. The patient had diarrhœa after the operation. A one-grain opium pill was given; ice to suck.

Oct. 5th.—Patient has not been sick since the operation; she feels easier. Wound dressed; there was very little discharge.

7th.—Diet: milk, beef-tea, bread-and-butter.

8th.—Bowels acted once yesterday; no diarrhœa. Wound appears somewhat swollen and inflamed.

10th.—Part of wound has healed by primary union; the inner part gapes a little; patient is in no pain.

12th.—Discharge rather purulent.

20th.—Wound very healthy.

24th.—Wound entirely healed.

Nov. 4th.—Patient has a well-fitting truss. Got up in the evening.

8th.—Went out apparently quite well, except for a cough.

CASE 2. *Dislocation of the left Knee-joint Outwards; Reduction; Cure.* (Reported by Mr. Paget.)—Philip D——, aged forty-eight, an ostler, was admitted into the Accident ward on Oct. 1st, 1884. The patient was leading a horse when it became frisky and knocked him down, twisting his leg He could not rise, and was brought to the hospital.

On admission there was dislocation of the left tibia and fibula outwards off the internal condyle of the femur. There was effusion of fluid into the knee-joint. Under chloroform the leg was flexed upon the thigh, and then extended with traction inwards, the thigh being held outwards. The bones slipped easily into their place. The fibula appeared a little loose. The leg was put upon a back splint with foot-piece, and cold, by means of Leiter's tubes, applied to the knee. One-sixth of a grain of morphia in solution was injected subcutaneously.

Oct. 2nd.—Did not sleep well. In a good deal of pain.

3rd.—Still in a good deal of pain, and there is considerable effusion into the knee.

21st.—Effusion going down. Ice bag still on.

28th.—Knee still feels hot. Left knee measures 14½ in. round; right knee 13¾ in.

Nov. 4th.—Bavarian splint put on.

14th.—The circumference of both knees is now the same.

CASE 3. *Lipoma of Scalp; Excision; Cure.* (Reported by Mr. Palmer.)—Henry H——, aged thirty-nine, a coachman, was admitted into Job ward, on Oct. 13th, 1884. The patient has had good health all his life. Twenty years ago he first noticed a swelling about the size of a pea on a level with the tip of his left ear and 2 in. posterior to it. It was pulpy and freely movable over subjacent bone, and not painful; this has gradually increased in size. On admission, the tumour is about the size of a hen's egg—i.e., 3½ in. from above downwards and 4 in. from side to side. It is soft and pulpy; there is no fluctuation; the bone beneath the growth appears to be excavated. The skin is not dimpled, and can be drawn together over it.

Oct. 14th.—Under chloroform, an elliptical incision was made from above downwards. The skin was dissected from either side of the tumour. The integument was found to be much adherent, and it was necessary to separate it down to the base of the swelling. The tumour was then removed, and the wound dressed with iodoform gauze. The growth was a pure lipoma.

21st.—The patient has had hardly any pain or inconvenience from the operation. The upper part has healed by primary union. The remainder is granulating.

Nov. 3rd.—Wound quite healed, and there is no discharge whatever. The patient feels quite well.

This case is worthy of record from the fact of the position of the tumour, lipomata being very seldom met with on the head.

BRISTOL GENERAL HOSPITAL.

CASES OF ANEURYSM IN THE LOWER EXTREMITY TREATED BY DIGITAL COMPRESSION; REMARKS.

(Under the care of Mr. NELSON C. DOBSON.)

CASE 1. *Simultaneous Aneurysm of both Popliteal Arteries.* T. F——, aged forty-three, a healthy, well-made man, a gamekeeper by occupation, and subject at times to considerable exertion in the way of walking and watching, was admitted in 1880. Has had gonorrhœa, but not syphilis; takes freely of beer, but is not a spirit drinker; his father suffers from gout, but the patient has never suffered from this; there is no albumen, and the heart sounds are normal. He states that two years ago he noticed an aching pain in the bend of his left leg, and some time since he discovered a swelling in the ham, which pulsated. He, however, continued to work regularly. Six weeks ago he noticed a similar swelling in the right ham.

When the man came under Mr. Dobson's notice there was an aneurysm in each popliteal space—that in the left being the larger, and measuring five inches in length and three inches in breadth; the swelling on the right side being as large as a hen's egg. Both swellings exhibited the ordinary characteristics of aneurysm, but in both firm pressure of the stethoscope was required to bring out the bruit. There was nothing abnormal about either limb otherwise. No other aneurysm could be discovered elsewhere. The heart was irritable in action, and the whole arterial system seemed to partake of the same irritability, both femorals at the groin pulsating unduly and giving one the idea that they were rather dilated at that point. He was kept in bed for a fortnight, and ordered a restricted diet according to Tufnell's plan, with for a few days five drops of tincture of digitalis

three times a day; and during the fortnight he was also given regularly five grains of iodide of potassium three times a day. Mr. Dobson did not attach much importance to the drugs, except perhaps that the digitalis steadied the circulation; he believed it to be a drug, though suitable to this particular case at the outset, which requires much caution in its administration in aneurysms. Probably diet and quiet were most useful of all the medical treatment.

On May 13th digital compression was commenced by relays of students. Prior to its commencement a quarter of a grain of morphia was administered subcutaneously, and a like amount after about eight hours. The method of applying the compression was in all cases the same—viz., first ascertaining the dead weight that would control the pulsation (in this case about seven pounds); a graduated bag filled with shot to this weight was made. The compressors were two at a time, the duty of one being to place his index, middle, and ring fingers across the artery at the pubes; the weight was then placed over the middle finger, and thus with very little exertion on the part of the assistant and with but small discomfort to the patient the circulation was controlled. The second assistant applied his hand lightly to the aneurysm, and immediately informed his colleague when the circulation was not effectually controlled. This last point Mr. Dobson considered most important, as he had formerly found without this observation on the part of the second assistant that the person in charge of the artery above was inefficiently controlling it. By the small expenditure of force required when aided by the weight, two assistants could work satisfactorily for two hours, changing places every twenty or thirty minutes. After sixteen hours the pulsation in the left popliteal was thought to have ceased. On the next day, however, as there was slight pulsation, digital compression was continued, and after three hours and a half it was finally left off. On the 17th there was a slight thrill in the sac, but no pulsation; and on the 19th there was slight pulsation in the posterior tibial. No especial symptoms followed the compression, and the aneurysm was cured. After giving the patient some days' rest, digital compression of the right femoral in the groin was commenced in the same way, and the aneurysm of the right popliteal was cured after eleven hours and a half. The after-progress was satisfactory and without feature. This patient was seen recently, and he was continuing quite well.

CASE 2. *Large Aneurysm of the Left Femoral at the Apex of Scarpa's Triangle.*—H. P——, aged sixty-three, a shoemaker, was admitted on Jan. 16th, 1885. He is an anæmic, flabby, delicate-looking man; never had syphilis. Four years ago he was kicked by a man in the region of the present swelling. There is a slight scar in the skin in this situation, but from careful inquiry the conclusion was arrived at that the blow had nothing to do with the aneurysm. The heart is sound, and no aneurysm was discovered elsewhere. The femoral is dilated in the groin, and pulsates forcibly. There is a swelling in Scarpa's triangle as large as an infant's head; he first noticed this about a month ago; it was then not larger than a hazel nut. There is not much pain, and no œdema of the limb. The swelling pulsates with marked distensile pulsation, and on auscultation there is a very decided bruit. The swelling is soft, and gives one the idea of its walls being tolerably thin; no arcus senilis; pulse 76. He was kept in bed, liberally fed, and had a mixture of iron and quinine for a week. On Jan. 23rd, at 10.45 A.M., digital compression, assisted by an 8 lb. weight, was commenced, a quarter of a grain of morphia having been previously given subcutaneously. The details were the same as in the former case, hot water bottles being placed in his bed, and the limb lightly wrapped in cotton-wool. 2.15 P.M.: The limb was blue and congested, with some amount of swelling generally. The patient was drowsy and pale, his pulse feeble, and he was sweating profusely. The tumour still pulsates. By 6.30 P.M. the congestion had passed off; it was probably occasioned by too much pressure, especially on the vein; the tumour is diminished in size; pulsation in the sac is not well-marked when pressure is taken off the artery. Compression was continued until 8.30 next morning (about twenty-one hours). There is still slight pulsation, but the sac feels firm and solid. On Jan. 27th, not being quite satisfied with the condition, Mr. Dobson ordered digital compression again for six hours, when the aneurysm was cured, and has remained so; the bruit had ceased entirely after four hours' compression on the second occasion. The tumour, which is now solid, is diminishing in size, and the superficial femoral above the tumour can be felt blocked. In the beginning of April this patient was again seen, and was remaining well.

Remarks by Mr. DOBSON.—The points of interest in Case 1 are that both popliteals were affected at the same time; the combination of weight, indirectly applied through the fingers of a skilled assistant; and the immediate appreciation of any defect in the process by his colleague who had charge of the aneurysm. These may seem small matters, but it is the small matters that make up the difference between success and failure in digital compression. I regard Case 2 as particularly successful, because I considered the patient a bad subject for any operative interference, and from his general condition, as well as the local condition of the artery, I felt sure that had digital compression failed the Hunterian ligature would have laid him open to more than ordinary risks. The blueness and congestion of the limb were very ugly to look at, but they soon passed off when the pressure was moderated. In both cases I endeavoured to check entirely the blood stream through the aneurysm during the compression. It was found necessary to caution the assistants against over-exerting themselves, there being a natural tendency to employ more force than was absolutely necessary to check the blood stream, but the success of the cases was attributed in a great measure to their intelligence and zeal. The first aneurysm was thus cured by nineteen and a half hours' compression divided into two terms of sixteen hours and three hours and a half. The second aneurysm was cured by eleven hours and a half of continuous compression; and the third by about twenty-one hours on the first occasion and six hours on the second, with an interval of three days between the two; a result which may be considered favourable when compared with the statistics of instrumental compression. Spontaneous aneurysms of the lower extremity are surgically amongst the most interesting of the aneurysmal class; but judging from my own experience in the Bristol General Hospital I should say that in this part of the country at least they are not common. I have only admitted under my own care during the last ten years three cases of this disease in the lower limbs, and I can only call to mind another instance of this disease in which my colleagues have sought a consultation during the same period. I have, therefore, thought that a short history of the two cases might be of surgical interest, not only on account of the complete success of the treatment adopted, but also as illustrating certain important points in the history of such cases, as well as allowing me the opportunity of emphasising the importance of the minute attention to detail which is necessary to bring to a successful termination any such case. With reference to the first case which I have mentioned, sufficient time—viz., five years—has elapsed to be certain of the permanence of the cure.

LEICESTER INFIRMARY AND FEVER-HOUSE.

STRANGULATED FEMORAL HERNIA WITHOUT CONSTIPATION; OPERATION; DEATH; NECROPSY; REMARKS.

FOR the following case we are indebted to Mr. C. J. Bond, house-surgeon.

E. H——, a healthy woman, aged fifty-seven, has suffered from right femoral hernia for four years, and has never worn a truss. The hernia had been reducible up to Nov. 27th of last year, when during exertion the tumour suddenly increased in size; in a couple of hours the patient felt sharp pain in the swelling, and vomiting occurred. From this date (Nov. 27th) up to her admission on Jan. 7th, 1885, she suffered more or less from vomiting, which came on at irregular intervals, and is said to have "smelt very bad" on one occasion. The bowels were moved irregularly at intervals of two or three days. Sometimes there was diarrhœa, and the last motion was on Jan. 4th, three days before admission. Up to this time she had been getting up, and went to see a medical man on this day. On her admission on Jan. 7th she was in a state of semi-collapse, but was operated on immediately. The little knuckle of gut, though red, was not very dusky, nor apparently much inflamed, and in no way gangrenous. The stricture, which was tight, was divided, and the gut returned. No omentum was seen. The patient never rallied after the operation, and died in a few hours.

Necropsy, with remarks by Mr. BOND.—The portion of intestine was found lying close to the opening of the crural canal;

the mark left by the constricting band was very plain, and, what is especially noteworthy, did not involve the whole circumference of the intestine, but passed obliquely on one side within about half an inch of the mesentery, and on the other rather nearer this edge; thus not obliterating the whole calibre of the bowel, but leaving a narrow channel along the mesenteric border of the gut. It is this fact which, I think, throws light on the peculiarity of the symptoms; for here is a case of strangulated hernia in which the strangulation is so complete in a portion of the intestinal tube as to lead to perforation, and yet in which, owing to the obstruction having been partial only, the symptoms are spread over a period of six weeks, and the bowels are moved, though irregularly, throughout that time. Attention seems to have been diverted from the real cause of the symptoms by the fact that though the patient vomited she did not get appreciably worse, and by the absence of constipation. The standard works on surgery mention no exception to the rule of complete constipation in strangulated hernia—in fact, do not refer to cases of strangulation of portions only of the whole calibre of the small intestine; and the condition doubtless is not common. At the same time there are specimens showing it in several of the London museums—two in that of University College, described in the catalogue by Beck and Shattock; but no account is given of the symptoms before operation. It would thus seem well to remember that it is possible to have cases of strangulation of a knuckle of intestine of such severity as to lead to perforation, there being no constipation, the symptoms resembling those of a case of chronic partial obstruction of the whole tube. At the upper part of the site of the stricture at one spot there was an opening into the intestine, through which fæcal matter had, evidently just before death and since the operation, escaped into the peritoneum, and helped to bring about the fatal result; there was no general peritonitis. In THE LANCET for March, 1882, I published some cases from which it seemed to me very probable that in cases of injury to the intestinal wall from extreme nipping, the perforation takes place from within outwards, and not from without inwards, commencing in ulceration and destruction of the mucous coat first, and, as in this case, nearly always at the site of the upper stricture, or that limiting the upper, full, dilated portion of intestine above the strangulated part. In this case it would also appear that the tight constricting band, though involving only a portion of the whole calibre of the gut, had by pressure caused not only ulceration of the mucous membrane at several points along its path, but at one point destruction of this and the muscular coats, leaving only the band itself, the thin peritoneum, and some plastic lymph to close the opening. As long as the knuckle of intestine remained *in situ* no escape occurred; but as soon as this band was divided, the adhesions broken down, and the intestine returned into the abdomen, fæcal matter rapidly escaped, though none was seen at the time of the operation, and the gut was for this reason returned instead of being left, with the stricture relieved, outside the abdomen, or an artificial anus being made.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Hæmaturia from Bilharzia Hæmatobia.—Experimental production of Chorea.

AN ordinary meeting of this Society was held on the 26th inst., Dr. George Johnson, F.R.S., President, in the chair. The meeting was prolonged for half an hour in order to discuss the second paper.

Dr. SPENCER COBBOLD read a paper on cases of Hæmaturia due to Bilharzia. The author explained that the terms "endemic hæmaturia" and "Bilharzia disease" can no longer be regarded as synonymous, and insisted upon the necessity of separating the dysenteries and hæmaturias that are, and that are not, due to parasites. Any measures of prophylaxis, to be successful, must have for their basis an intimate knowledge of the genesis of the parasite, and to this end the author had made some experiments with very young specimens of Helix alliaria; these molluscs were subjected to the action of the swimming ciliated embryos; the latter, however, though constantly sticking to the snails, refused to penetrate their bodies. The living ciliated larvæ were next subjected to the action of certain drugs: alcohol, santonin, salt, &c. The embryos were found to be excessively sensitive to stimuli of all kinds. Thirteen cases of the disease were fully described. Post-mortem investigations have shown that the home of Bilharzia is the portal system, where the adult worms have been found in great numbers, including, however, but few females, and only a small proportion in sexual combination. The eggs accumulate within the chylopoietic branches of the portal vein, and also within certain systemic veins that anastomose with them. To the dispersion of the eggs nearly all the symptoms of the disease are due, and the intimate relation between the chylopoietic veins and the systemic veins supplying the genito-urinary passages is sufficient to explain why the kidneys, ureters, bladder, and rectum are all liable to become the seat of the disease. An outline of Sonsino's classification of the Bilharzia infarcts was given. The author considered the remarkable variations of the eggs of Bilharzia to have no pathological or clinical significance. The employment of medicated injections and "surgical treatment" were both condemned, and reliance was rather placed on good climatic conditions, general tonics, and other means, to aid the curative efforts of nature. Dr. Cobbold showed eleven specimens of the adult worm, six of the worm as it occurred in the human being and five in the ox. Dr. Sonsino had also sent him through the kindness of Sir Joseph Fayrer a specimen of Bilharzia crassa, which was a larger and stouter parasite, the eggs were different from B. hæmatobia, and had spines at both ends. He showed several other kinds of Bilharzia, some of very large size. Mounted preparations of a bladder which showed miliary infarcts in the left seminal vesicle were also exhibited. Some stones which had been removed by cystotomy had been sent to him by Dr. Kartulis; the eggs formed the nuclei of the calculi. Photographs and microscopic preparations illustrated the paper.—Dr. GEORGE JOHNSON said that the main point of contention was as to the effect of local treatment.—Dr. JOHN HARLEY said that it was to be wished that we had completed the life history of the parasite, but he thought that no advance had been made. He referred to his original observations on the subject. He could not agree that improvement in the general health was necessary for the cure of the disease. Very healthy people took the disease, and large numbers of robust individuals suffered from it. Nephritic colic was sometimes observed as the result of the disease. Whereas no cure had been effected in Dr. Cobbold's cases, he had had one case under his care in which local treatment was attended with success. He spoke of the value of soluble drugs like iodide of potassium injected into the bladder; also of the use of the oil of the male fern. He had never recommended the use of perchloride of iron, and condemned anything like heroic treatment. His remarks were illustrated by reference to cases which had been under his care.—Dr. COBBOLD, in reply, thought that cures of the disease might be mere delusions, for the parasite may exist for a long time without giving rise to symptoms. He was glad that there was so little divergence of opinion in regard to treatment. Reference was made to the observations of Mackie, in some of which the ova were found in the rectum and sigmoid flexure, but not in the bladder. The parasites did not enter the bladder through the urethra. The notion that the parasites were free in the bladder was an erroneous one. The "bedchamber" and principal seat of the parasites was the portal system, and Kartulis had counted no less than 300 specimens (and the number might be much greater) sexually combined in the portal vessels of one case.

Dr. ANGEL MONEY read a paper on the Experimental Production of Chorea and other results of Capillary Embolism. The experimental investigation of which this communication is the first contribution was begun in October, 1884. The animals used have been rabbits, guinea-pigs, cats, and dogs. The emboli found most suitable were arrowroot particles, granules of potato starch, and carmine. The particulate liquid was generally injected into the common carotid artery. Sometimes the injection was made towards the brain, but, as a rule, the liquid was injected towards the heart. It is exceedingly easy to produce embolism of the capillaries of the brain, but it is very difficult to get emboli into the capillaries of the upper part of the spinal cord without causing death by paralysis of respiration. The most important clinical observation which has come out of the experiments is the production of involuntary movements

indistinguishable from those of chorea. These movements have not been accompanied by appreciable paralysis or spasm. The chorea of the animals experimented on never resulted from capillary embolism of the brain. In nearly every animal in which the brain was affected with capillary embolism some form of "uncontrollable" movement was present, allied, the author believes, in essential nature to chorea. The "chorea" of the animals experimented on was always the result of embolism of the capillaries of the spinal cord. The want of development of the pyramidal tracts in the animals under consideration possibly affords an explanation of the reason why chorea does not in them result from embolism of the brain proper. The author is of opinion that the reasons given for locating the lesion of most cases of chorea in the human subject in the brain are too powerful to be upset by experiments on animals so far removed from man as those experimented on by him. When the "chorea" of the animals experimented on was well marked, reflex action in the spinal cord was exaggerated. The suggestion is made that in the few cases of chorea in the human being where the reflexes are exaggerated, the spinal cord will be found to be the seat of the pathological condition. Rhythmical repetitions of one movement and also irregular succession of different movements have both been observed, so that experimental "chorea" both resembles and differs from the chorea of man and the ordinary chorea of dogs. Spinal paralysis has been observed as the result of the author's experiments, and also complete facial palsy. The respiration and cardiac action are variously affected by capillary embolism. The temperature appears to be always lowered, but it is difficult to eliminate the influence of the shock of the operation. Capillary embolism may give rise to any symptom of disease of the nervous system. As a rule, the capillary emboli gave rise to no pathological lesion recognisable by the microscope or naked eye. The view is supported that chorea is due to defective nutrition of the same kind as that which leads to paralysis, though in a less degree. This defective nutrition may be brought about by many causes, of which embolism is one. The relationship of chorea to involuntary movements generally was discussed. Suggestions were made for differentiating the varieties of chorea.—Dr. HUGHLINGS JACKSON thought the paper was one of great value. That irregular, involuntary movements of any kind had been produced by artificial embolism was a very important thing. That the movements were or were not like those of chorea in man was not the question of first importance, although one of great moment. We could in no circumstance expect to see abnormal movements in a dog's forelegs, like the elaborate movements of a child's arm in chorea; the dog was not capable of such movements. The fact that in human chorea the movements were very elaborate, was some evidence as to localisation—pointing to the morbid affection of some part of the nervous system "high up," where the nervous arrangements were very special and complex. Since 1864 Dr. Hughlings Jackson had held that the seats of the lesions in chorea were convolutions near the corpus striatum, at the same time, after Kirkes, suggesting that the lesion was often owing to plugging of small arteries; he had never undertaken to show that this process was the sole one productive of chorea. That some convolutions did represent movements was, since the experiments of Hitzig and Ferrier, certain. As the face was affected in chorea, it was clear that there was some lesion above the spinal cord; cases of hemichorea in which the face was affected were inexplicable on the view that the lesion was spinal only. Certainly cases of post-hemiplegic chorea and pre-hemiplegic chorea were inexplicable on that view; in these cases, indeed, cerebral lesions had been found (Weir Mitchell, Charcot, Raymond, and Demange). It might, however, be said that in ordinary chorea in man spinal lesions also were concerned; they had been found by Dickinson and Ross. Again, it had been proved by Legros, Chauveau, Carville, and Bert, that in a choreic dog the abnormal movements of its foreleg persist after section of the cord above the origin of the nerves for that limb. Dr. Hughlings Jackson had found the same. In the canine chorea of veterinarians the movements were rhythmical, and it did not follow that in this animal such comparatively simple movemements might not be capable of development from activity of spinal centres, whilst they might not be so in a higher animal, as in man much more elaborate movements were often seen. Albertoni, Franck, and Pitres affirmed that an epileptiform seizure started in a dog by faradaic irritation of some part of its motor cortical region, continued in spite of sudden removal of the part of the cortex excited. An objection often brought against the hypothesis of embolism and thrombosis was that these processes led to destruction of nervous elements. That was perfectly true; and it need not be said that from destroyed nerve tissue there could result no movements of any sort. But then it was equally true that with destructive lesions there sometimes occurred over-development of movements—e.g., post-hemiplegic chorea. It is certain, too, that epileptiform seizures occurred in some cases of local cerebral softening from thrombosis or embolism. A condition for repeated seizures was established. In these, and in most cases of chorea, everyone had two opposite motorial states to account for, some paralysis and some over-movement. Destruction of some nervous elements from embolism could only account for the paralysis in chorea; there must be on any hypothesis an over-activity of some other nervous elements to account for the co-existing over-movements. He reasserted that over-movements of some kind (post-hemiplegic chorea, athetosis, epileptiform seizures) do occur in cases where there are destructive cerebral lesions. Dr. Hughlings Jackson thought the researches of Dr. Dickinson (Med. Chir. Trans., vol. 59) went a long way towards proving the hypothesis of embolism and thrombosis as a cause of chorea. He said this with great respect, as Dr. Dickinson rejects that doctrine. Dr. Dickinson said the lesions in chorea were determined in position by the course of the arteries in the brain notably by the middle cerebral, which, as he stated, are the favourite routes of emboli. He wrote, "The first visible change would seem to be the injection or distension of the arteries, succeeded by extrusion of their contents to the irritation and injury of the surrounding tissues." Was not this like a description of embolism or thrombosis? He found also spots of sclerosis "degeneration of nervous elements;" the sclerosis was usually periarterial. Now, this sort of change, the sclerosis, a negative one, softening in miniature, could not cause movements of any kind. There must be another change, an opposite one, else there would not be the over-development of movements. Moreover, Tuckwell, Bastian, and Ross, had found plugging of arteries in some cases of chorea. Dr. Ross in his great work on Diseases of the Nervous System related a very important case, confirming Dr. Richardson's observations. Ross found plugging of anterior or antero-lateral arteries of the cord, and also necrotic spots in the corpora striata. Regardless of any hypothesis, Dr. Money's researches proved that in some way some involuntary movements are producible by embolism. It could scarcely be but that his work would be of great scientific and practical importance; it constituted a new starting point. Dr. Hughlings Jackson concluded by remarking that in chorea there was often a condition for embolism or thrombosis; that the movements were hemiplegic or double hemiplegic; that emboli most often did get into the middle cerebral artery which supplies the convolutions supposed to be morbidly affected in chorea, and that slight faradaic excitation of these convolutions did produce elaborate movements, although it was not yet proved that it set up a persistent condition for a quasi-spontaneous succession of different movements at different intervals as such as occurred in chorea.—Dr. CHARLEWOOD TURNER contributed some observations from fatal cases of chorea in the child. Some large nervous cells taken from the third layer of cells at the fissure of Rolando were much swollen and distorted; these were large polar cells. The nuclei were obscured. All the cells of this layer were not affected. A paralytic condition of the motor nerve cells in this particular part of the brain, from which volitional impulses are transmitted to the muscles, might account for the phenomena of chorea. In chorea no properly arranged movements were possible. If the control of the highest centres were removed, then the emotional movements would be increased in activity; for it was probable that the movements of emotion were energised from other parts of the grey matter of the brain. Reference was made to the views of Dr. Hughlings Jackson on the alliances of incoördination with paralysis. Dr. Turner thought the embolic theory scarcely sufficed to explain the phenomena of chorea, for the effects of capillary embolism soon passed away. Where permanent destruction was caused as the result of embolism paralysis resulted.—Dr. OCTAVIUS STURGES spoke of the great value of the experimental investigation made by Dr. Money. He, however, thought there were clinical points in chorea which showed that chorea could not

be due to structural lesions. A slight febrile attack or an acute specific fever, such as scarlatina or typhoid fever, would abolish chorea, and the chorea would not return so far as he knew on recovery from the acute specific fever. Then there were other points in the history of chorea which went against the embolic view. The sexes were so differently affected, and in a matter of race there was so much difference. Indians were but little affected. The movements observed in animals, though they were spoken of as chorea, did not appear to him to be of that nature. Again, emboli were absent in most cases of fatal chorea occurring in children. He questioned whether the movements observed by Dr. Angel Money ought to be called chorea.—Dr. COBBOLD drew attention to some observations made by Böllinger, Friedberger, and others of aneurysm in the horse, which was so frequent in horses more than seven years old. It was stated that 90 per cent. of such horses were affected with this "worm" aneurysm. The worm was called strongylus armatus. Various irregular nervous movements resulted from the introduction of these worms into the arterial circulation, into which they got from the aneurysms.—Dr. JOHN HARLEY said that he had shown that cryptopia could give rise to choreic movements. Narceia dissolved in glycerine and injected under the skin of small animals gave rise to lethargy and convulsions. The alkaloid was absorbed into the circulation and deposited in the tubules of the kidneys and produced a physical anuria which no doubt gave rise to the convulsions, which set in about three hours after the hypodermic injection. He asked whether there were any emboli in the kidneys in Dr. Money's experiments.—Dr. BROADBENT said that the paper required a great deal of careful reading, but it was plain that the whole investigation was one of immense value, and it opened the door to further investigations, which could not but be productive of great results. Speaking of human chorea, he thought age rather than race and sex was the most important factor. He had held that capillary embolism was one cause, but by no means the sole cause, of chorea. Dr. Money had shown that almost every symptom of nervous lesion could be caused by capillary embolism. The rhythmical movements in animals were not the equivalent of chorea in the child. Human chorea was distinctly a cerebral affection, as the cases of hemichorea also bore out. He had more than once seen hemichorea followed by paralysis and reappear as the palsy disappeared. He knew also that febrile affections caused chorea to disappear.—Dr. ANGEL MONEY, in reply, contended that he had not suggested that chorea was usually caused by embolism. His observations merely pointed to the conclusion that embolism was a probable cause in some cases. He considered that Dr. Sturges was not in harmony with clinical observation in believing that chorea was always due to one cause. Dr. Money's chief contention was that any symptom of disease of the nervous system could be caused by capillary embolism. Chorea was due to a defective nutrition of certain parts of the nervous system, and this defective nutrition might be brought about by many means, embolism among the number. He had stated in his paper that the reasons for locating the lesion in the brain in human chorea were irrefutable. In reply to Dr. Harley, he said that there were no emboli in the kidneys, and that the spontaneous movements came on immediately after the injection of the artificial emboli into the arterial circulation. He thanked Dr. Cobbold for the information given with regard to embolism in horses.

PATHOLOGICAL SOCIETY OF LONDON.

Varicella Gangrenosa.—Thrombosis of Veins from Gonorrhœa.—Addison's Disease.—Atrophy of Adrenals.—Rodent Ulcer.—Secondary Glioma.—Calculus in both Ureters.

THE last ordinary meeting of the session was held on Tuesday, the 19th inst., Dr. J. S. Bristowe, F.R.S., President, in the chair. The subject of the relations of Addison's disease to the adrenal bodies was in the ascendant.

The report of the Morbid Growths Committee on Mr. Treves' cases of tumour of the soft palate was read by Mr. Shattock. The report stated that the first tumour was an alveolar sarcoma; the second tumour was a spheroidal-celled carcinoma, but not improbably it had commenced as an adenoma.

Dr. PAYNE read notes of a case of Varicella Gangrenosa, which occurred in a girl aged three years. An ulcerated eruption was seen on admission to the hospital, and varicella had been present a month before. At the autopsy there were signs of acute miliary tuberculosis; to his knowledge there was only one other post-mortem record, and this was by Dr. J. Abercombie; in this case tubercular disease, not so extensive, was also present. It might be a mere coincidence that tubercle and varicella gangrenosa should be associated, though it might possibly be a factor in the explanation of the occurrence of gangrene in such eruptions. He discussed the other possible relations of the two affections. The combination of the varicellar and tubercular poisoning, if not inducing the gangrene, might at all events have led to the fatal result of the two cases in question.—Mr. BOWLBY showed a drawing of a case of varicella gangrenosa made from the body of a male child aged ten months, who had had varicella fourteen days before he was first seen. There were altogether six gangrenous patches. The infant recovered and left the hospital; it died a day after in convulsions, but no necropsy could be obtained. A second case, that of a female child aged eight months, who had had doubtful varicella ten weeks before admission, was narrated. The vesicles became purulent and ulcerated, and some went on to a sloughy state. A fresh crop of vesicles came out whilst the patient was in hospital, but none of these went on to gangrene. The third case mentioned was that of a female infant aged eighteen months. The sores were much the same as in the other cases. No doubt a gangrenous condition might supervene on cutaneous eruptions which were not varicella, though they were vesicular, and possibly the second case was of this nature.—Dr. RADCLIFFE CROCKER had seen two fatal cases and some of an intermediate degree. The tubercular association of gangrenous ulceration was suggested by Dr. Barlow some time ago. In one of Dr. Crocker's fatal cases there was a strong tubercular history, and it was said that an elder brother died from tubercular peritonitis. In some cases of gangrenous eruption there was no distinct history of chicken-pox. The gangrenous condition did not always appear to come from the varicellar eruption itself, but in the skin which had not been the seat of the varicellar vesicles. There were, he thought, various grades of the affection; deep pustules sometimes formed and healed without any gangrene supervening. The gangrene sometimes appeared as the varicella was subsiding. In other cases, as in one of Mr. W. Haward's, the fourth day was the date of the onset of the gangrene. A septic change occurring in the secretion might explain some cases. Death from pyæmia was not unknown in connexion with these eruptions. Evidence of tubercle was not to be obtained in some of the cases. In his experience the eruption sometimes appeared to be benefited considerably by sulphocarbolate of soda administered internally.—Dr. PAYNE, in reply, had not been aware that Dr. Barlow had suggested that tubercle was an active agent in bringing about the gangrene of such cases as those in question, though he had some recollection of such a suggestion in connexion with vaccinia gangrenosa.

Mr. HILTON POLLARD showed a dissected specimen of the Pelvic Viscera and Veins of a case of Thrombosis consequent on Gonorrhœa. The patient was a woman aged nineteen, who had suffered from gonorrhœa for thirty-six days before death. The other symptoms present were pyrexia, the temperature ranging between 100° and 102°; some pain in the knee and fixation of the right hip-joint. The symptoms of disease of the hip-joint were at times equivocal. Death was due to embolism of the pulmonary arteries. The specimen showed thrombosis of the left common iliac vein, left internal iliac vein, and vaginal veins. There was no ulceration in the vagina. The cartilage of the femur and acetabulum of the right hip-joint was eroded, and the joint contained purulent material. No other joints were affected. Mr. Pollard thought the case remarkable in that so serious a set of conditions should complicate a case of gonorrhœa without giving rise to symptoms sufficient to call attention to the perilous state of the patient.

Dr. SAUNDBY showed the Spleen and Semilunar Ganglia of a case of Atrophy of the Suprarenal Capsules. The patient was a female aged eighteen. At the age of thirteen she was first seen, and it was noted that she had a somewhat Italian cast of countenance and complexion. She was treated afterwards for anæmia, amenorrhœa, and other disorders, but Addison's disease was not then suspected as the cause of her ailments. About August, 1884, there was pyrexia, and then the spleen was found to extend to the umbilicus, being much

enlarged. An attack of faintness in January, 1885, was premonitory to a fatal seizure, from which she died comatose a few days later. All her life the urine had been dark and contained a large quantity of indican; a trace of hæmoglobin was found on one occasion. The heart was somewhat hypertrophied. Some pigment arranged in chains in the cortex of the kidneys was seen in sections of these organs. The adrenals were much atrophied; one weighed ten grains and the other eighteen grains. The spleen weighed sixty-six ounces. He referred to McMunn's spectroscopic researches, which seemed to lead to the inference that the function of the suprarenal bodies was to destroy the effete blood pigment. Other points of interest in the case were referred to. The father died at thirty-seven with an enlarged spleen and passed black urine all his life, and a brother had an enlarged spleen and many attacks of melanuria. Dr. Saundby commented on the three important elements of an enlargement of the spleen, of the dark-coloured urine, and of the occurrence of these symptoms in one of three members of the same family in which these symptoms coincided. In Greenhow's work mention was made of an enlargement of the spleen in two cases, but no stress was laid on it. Rosenstein, in the fifty-sixth volume of Virchow's *Archiv*, stated that he had found a large quantity of indican, ten times the normal quantity, in the urine of cases of Addison's disease.

Dr. SEYMOUR TAYLOR read notes of some cases of Addison's Disease. The first was that of a female, single, aged thirty-five, who had all the signs well marked of Addison's disease. The pigmentation was typical. The viscera were healthy; the capsules were in the ordinary cheesy condition; the spleen was not enlarged. No tubercle was found in the other viscera; there was no pigment on the vagina; the labia minora were pigmented, especially about the nymphæ. Sections of the nymphæ were shown, which presented a great contrast between the external and internal surface. The pigment was seen in the rete mucosum and in the intercellular cement in the deeper layers of the epidermis. There were also many scattered pigment granules in the cutis vera. The second case presented the same changes in the nymphæ. Neither of the two women had been pregnant, and so the pigmentation could not have resulted from pressure on the veins.

Dr. HADDEN read notes of a case of Atrophy of the Suprarenal Capsules with Addison's Disease. The patient was a single woman aged thirty. Vomiting was the first symptom, and began eight months before admission. The tongue and gums became pigmented. Pigmentation of the skin and mucous membranes was present on admission to hospital. The superficial reflexes were marked; the knee-jerk absent. Constant vomiting, attacks of fainting, headaches, and drowsiness were the main symptoms. Death took place suddenly three weeks after admission, just after an attack of vomiting. At the autopsy pigmentation of the vulva, skin around the anus, and upper end of the gullet were noticed. There was no tubercle anywhere; the adrenals were equal and distinctly small; the diminution was specially noticeable in thickness; the shape and colour were normal; the free edge was irregularly notched. The length of the left suprarenal was one inch and a half and its breadth three-quarters of an inch. The connective tissue around the capsules and sympathetic nerves was healthy. Microscopically, the suprarenal body showed much fibrous thickening of the investing capsule. There was a richly fibrous nucleated growth in the zona glomerulosa. Many of the cells were atrophied, and most were replaced by the newly formed tissue. In some parts the cell spaces were surrounded by dense fibrous tissue, and the spaces themselves were empty or contained atrophied cells. The nucleated growth passed inwards between the columns of cells in the zona fasciculata, separating them into islets. In many places the epithelial cells had undergone nuclear proliferation. The medulla was very scanty and difficult to distinguish. There were large areas of round cells, similar to those seen in the suprarenal body, in the semilunar ganglia. There was also a little granular pigment in the connective tissue. The nerve cells were probably healthy. The lymphatic glands were healthy. The state of the adrenals resulted from a chronic interstitial change, similar to that seen in cirrhosis of the liver. The lesion was identical with that of the thyroid gland in myxœdema. He regarded it as probable that no constant morbid change is essential for the production of either Addison's disease or myxœdema. The lesion must be a destructive one. Tizzoni's experiments were referred to as proving that in rabbits pigmentation of the skin occurred after destruction of the suprarenals. It was difficult to say that the change in the semilunar ganglia had any share in the production of the disease. Nevertheless, it was probable that the sympathetic nerves are at fault in Addison's disease. The rich supply of nerve fibres to the semilunar ganglia suggests that there is a relation between them and the sympathetic. Destructive disease of the adrenals must involve the nerve fibres which enter them. There may be a supplementary relation between the two, or the suprarenals may exert a controlling or moderating influence on the sympathetic.

Dr. KINGSTON FOWLER showed the Adrenals and Semilunar Ganglia from a case of Addison's Disease, which occurred in a woman aged twenty-six who was under the care of Dr. Cayley at the Middlesex Hospital. The duration of the disease was three years. The illness began with an attack of vomiting, which lasted one week. These attacks became more frequent. The pigmentation was fairly marked. Syncope closed the scene. The adrenals were much atrophied. The right one was calcified and contained a caseous nodule in the centre. The left one was still more contracted. The nerves did not present any obvious changes. The case was doubtfully one of Addison's disease. He thought that Dr. Saundby's case was not an ordinary one of Addison's disease, and if there were any of the Addisonian element in it, it was probably mixed up with some other diathesis.

Dr. SAMUEL WILKS considered that the occurrence of atrophy of the adrenals supported Addison's original contention, which was to the effect that any destructive lesion could cause the symptoms of the disease. It was true that many cases of cancer, effusion of blood, and abscesses of the adrenals had been shown in which no symptoms of Addison's disease were present; but then he contended that both the adrenals were not destroyed by such conditions. The disease which could cause absolute destruction must be a slow integral change and probably of an inflammatory nature. In the early stages of such a change the organ might be enlarged, subsequently degeneration of a fibrous, calcareous or caseous or mixed kind would occur, whereby the organ might be totally destroyed. Such changes were to be seen in the liver and kidneys, which, however, being more vital organs, could not be totally destroyed without causing death. In the mamma and testis such changes could lead to the complete disappearance of the organs.—Dr. HALE WHITE did not doubt that the ganglia in Dr. Hadden's case did not present an abnormal appearance. He thought we should not pay too much attention to the abnormal change. Addison's disease could occur without any change in the ganglia that could be recognised by histological examination.—Mr. VICTOR HORSLEY did not think the evidence supported the doctrine of disease of the sympathetic nerves as the cause of Addison's disease.—Dr. BRISTOWE thought the evidence so far adduced confirmed the original statement of Addison that the disease was caused by anything that destroys the adrenals completely. The view that Addison's disease was a tubercular disease of the capsules was not the correct one. He believed that the special function of the capsules was not a nervous one, though it was one which was essential to the well being of the economy. He conjectured that these bodies have certain special duties to perform in the way of removing waste products, or else as supplementary to other functions; and when these functions were disturbed, the organism suffered in some definite way which we clinically recognised as Addison's disease.—Dr. WILKS repeated that it was only possible to get total destruction of the bodies when there was an integral change in the organ itself. And he doubted whether any adventitious disease could cause complete destruction of both adrenals.—Dr. SAUNDBY said the spleen was of a dark-purple colour, soft and pulpy. A large amount of pigment scattered amongst the cells was seen in microscopical sections. There was simply atrophy of the adrenals and no fibro-nucleated growth. He regarded it as a case of primary atrophy. The semilunar ganglia showed no special change. His own experience strongly supported the view which Dr. Hadden had advocated.

Dr. THIN gave an account of the sequel of a case of Rodent Ulcer fully described by him in 1879 in the Pathological Society's Transactions. The theory of the structure of rodent ulcer therein advocated was still maintained by him. The man since 1879 had been admitted into Middlesex

Hospital under the care of Mr. Morris, where he was in 1881. His death took place in September, 1884. The disease had spread from its original site on the scalp, when it was the size of a five-shilling-piece, until it had caused great destruction of the neck and side of the head. The distinctive and characteristic histological appearances were still to be observed in the borders of the large destructive ulcerating mass. The idea that a rodent ulcer becomes epitheliomatous was not borne out by Dr. Thin's case.

Mr. GEORGE LAWSON exhibited the drawings and post-mortem preparation of a case of Secondary Glioma. The patient, a little girl aged two years and two months, had the left eye removed by Mr. Lawson in December, 1883. In January, 1884, he removed the right eye, as it was distended with a gliomatous tumour, causing great pain. From both these operations the child rapidly recovered, and from each experienced great relief. In the following month, February, the child was admitted into the Middlesex Hospital with a recurrence of the tumour in the left orbit. The tumour continued to grow until it not only protruded beyond the orbit but covered the whole of one side of the face, overlapping the nose, the mouth, and the lower jaw. The child was kept free from pain by repeated small doses of morphia, and she took her food well. She died on August 3rd, 1884. There were no brain symptoms until a few days before her death, when she had several epileptic convulsions. At the post-mortem examination the whole of the left side of the face was occupied by a large tumour, slightly ulcerated in places. There were no secondary deposits in the organs of the chest or abdomen. In the fibres of the right deltoid muscle there was a lobulated mass, having the same appearance as the orbital growth. On removing the calvaria the dura mater was seen to be covered at irregular intervals with deposits of glioma varying in size from a pea to a penny. On cutting through the membranes, the convolutions were seen somewhat flattened and the meningeal veins distended. On removing the brain a tumour about the size of a small orange was seen occupying the pituitary fossa and neighbouring portions of the sphenoid bone, apparently having originally sprung from one or both optic foramina.

Mr. CULLINGWORTH (Manchester) showed specimens of Impaction of a Large Calculus in each Ureter, which were taken from a woman aged thirty who had had a swelling in the right side for two years; the symptoms dated back ten months, when a distinct attack of pain in the back and right side was first experienced, and during which attack there was much pus in the urine. This attack lasted two weeks, and similar attacks came on from time to time. Pyuria was observed to the extent of half the quantity of urine passed. An operation with a view of removing the diseased kidney or relieving the pyo-nephrosis was undertaken by the abdominal section. The right ureter was found to be obstructed immediately above its opening into the bladder. The ureter was opened, and a calculus was removed which was the size of a walnut. Three days afterwards symptoms of uræmia set in and the patient died. At the autopsy the left kidney was also found to be full of abscesses, the ureter was dilated and contained a calculus at its lower end. Had the existence of disease in both urinary tracts been suspected, he should not have operated in the way he had done. The pus came from the left kidney, for the right ureter was perfectly impervious as the result of the impaction of the stone.

The following card specimens were shown:—

Dr. Goodhart: (1) Viscera from a case of Phosphorus Poisoning; (2) Specimens of Leprosy of Hand and Larynx for Dr. Beaven Rake of Trinidad.

Dr. Burnet: Primary Melanotic Sarcoma of Liver.

Mr. Makins: Primary Sarcoma of Tibia.

Dr. Sharkey: (1) Impaction of a Coin in the Œsophagus for twenty months; (2) Aneurysm of Heart; (3) Multiple Epithelial Growths in the Œsophagus.

Mr. Poland: Sections of Epithelial Growths in the Viscera after Epithelioma of the Tongue.

Dr. Chaffey: (1) Multiple Sarcoma in a child; (2) Lymphosarcoma of Bladder.

Mr. Hutchinson, Jun.: Epitheliomata of Hand.

Mr. Arbuthnot Lane: (1) Bony Process from Humerus; (2) Displacement of Foot from Fracture of Bones of Leg; (3) Fracture of Sternum.

Dr. Gilbert Barling: (1) Round-celled Sarcoma of Peroneus Longus; (2) Alveolar Sarcoma of Triceps.

Dr. Hale White: (1) Perforating Tubercular Ulcer of Intestine; (2) Grain of Corn causing Typhlitis and Intestinal Strangulation.

Dr. C. Turner: Aneurysm of Aorta communicating with the Superior Vena Cava.

Mr. Shattock: Hernia into the Fossa Duodeno-jejunalis in a child.

Dr. Hebb: Melanotic Sarcoma of Spleen, &c.

Dr. Dawtrey Drewitt: Persistent Branchial Fissure in a child (living specimen).

Mr. F. B. Jessett: Lower Jaw removed by operation for Cancer (recent specimen).

Mr. A. E. Barker: Gangrene of Finger Ends, probably due to syphilitic arteritis.

Mr. Bland Sutton: Difficult Labour in a rickety monkey.

CLINICAL SOCIETY OF LONDON.

Report of the Committee on Spina Bifida.—Successful Œsophagotomy.—Raynaud's Disease.—Surgical Treatment of Tumour of the Bladder.

THE last meeting of the session of this Society was held on May 22nd, Mr. Thomas Bryant, F.R.C.S., President, in the chair.

The report of the Committee on Spina Bifida was read by Mr. R. W. PARKER. The subject was divided into two parts: (1) the pathological anatomy of spina bifida; (2) its treatment.

1. *Pathological Anatomy.*—The term "spina bifida" was used to define certain congenital malformations of the vertebral canal with protrusion of some of its contents in the form of a fluid tumour. With very rare exceptions the malformation affected the neural arches of the vertebræ, and the tumour projected posteriorly; in rare cases, however, the bodies of the vertebræ were involved, the tumour in such cases protruded anteriorly into the thorax, abdomen, or pelvis between the lateral halves of the bodies affected. The museum specimens were discussed under the following headings:—(1) Position of tumour; (2) size and configuration of the sac; (3) coverings of sac; (4) disposition of meninges within the tumour; (5) size and configuration of the deficiency in the neural arches; (6) disposition of the spinal cord and nerves; (7) unusual variations; (8) the process of cure. The result tended to show that the specimens fell under three divisions:—(1) Protrusion of membranes only (simple meningocele); (2) protrusion of membranes together with the spinal cord and its appertaining nerves (meningo-myelocele); and (3) protrusion of the membranes together with the spinal cord, the central canal of which was dilated so as to form the sac cavity, the innermost lining being constituted by the expanded and atrophied substance of the cord (syringo-myelocele). The committee stated that the meningo-myelocele was by far the most frequent, while simple meningocele came next, and syringo-myelocele last. As a typical example of the common kind, a specimen now in the College of Surgeons was quoted. This was a case of lumbo-sacral spina bifida, the size of a Tangerine orange, sessile, but constricted slightly at the point of attachment. The tumour presented normal skin for a short distance round its base, but the central portion consisted of a thin translucent membrane; along its vertical axis the tumour was slightly furrowed, this furrow corresponding to the attachment of the cord to the inner surface of the sac wall. The spinal cord ran almost horizontally across the upper part of the sac, and then became incorporated with the sac wall, from which also the lowest nerves arose; they then passed across the sac to gain the intervertebral foramina, from which they issued normally. The anterior and posterior roots of the nerves were separated from each other by an exaggerated ligamentum denticulatum. A careful dissection was often necessary in order to distinguish simple meningocele from syringo-myelocele. Mention was made of several variations; among these the division of the sac into smaller loculi, and the occurrence of bony outgrowths across the vertebral canal button-holing the spinal cord, were the most remarkable. Careful microscopic examination of the sac wall in a typical case of meningo-myelocele had disclosed the continuation of the central nervous system within its median vertical portion, the integrity of the central canal of the cord within this part, and the absence of true skin over it. It further displayed the absence of any meningeal cavities behind the incorporated portion of the spinal cord; it was clear, therefore

in the first place, that the nerve roots, which traverse the sac, arise from this intramural portion of the central nervous system, and that all expressions of descriptive pathological anatomy which imply a distribution of the nerves to the sac wall are a reversal of facts. Even more important than this, the histology of the sac wall in a typical case, by demonstrating the integrity of the central canal of the included portion of the cord, showed beyond dispute that the neural furrow does not remain unclosed in spina bifida, nor after having been closed is it subsequently distended by dropsy and ruptured. The absence of true skin from the central portion of the sac wall was next adverted to. The membrane implied that the mesoblastic basis of the true skin, and the structures lying in subjacent connexion with it, had not been developed. The presence of the cord in the sac wall offered no difficulty of explanation when its epiblastic origin was remembered. The theory therefore which best explained the pathological anatomy of spina bifida was that which assumed a primary defect of development of the mesoblast from which the structures closing in the vertebral furrow were developed.

2. *Clinical Course and Treatment of Spina Bifida.*—In order to form a correct estimate of the value of treatment by the injection of Dr. Morton's iodo-glycerine solution, the committee had endeavoured to ascertain as far as possible the natural history of the deformity when untreated, and had prepared tables of cases treated in various manners for purposes of comparison. As regarded the natural history of the deformity, the Registrar-General's report for 1882 showed 649 deaths from spina bifida in England and Wales, of which 612 died under one year of age. The committee held that, though a certain number of these deaths were due to local causes—rupture of the sac, draining away of the cerebro-spinal fluid, and subsequent septic meningitis—yet in a large proportion of cases death ensued from the marasmus and general defective nutrition so frequently associated with the deformity, and which could not be remedied by any local or other treatment. The tables next dealt with treatment by injection with simple solutions of iodine, and showed a considerable amount of success. Then ligature of the sac was considered, and here again good results seemed to have been obtained. Excision likewise had a considerable proportion of success. The plan of repeated tapping and pressure gave the least successful results of any. The injection of Morton's fluid, according to the committee's tables, showed a percentage success of between fifty and sixty. The high mortality was thought to be largely due to the treatment having been adopted in unsuitable cases on account of its simplicity and supposed safety. In spite of the favourable results of ligature and excision of the tumour as shown in the tables, the committee felt themselves compelled to report against these methods of treatment. There was reason to think that the published cases might be misleading, owing to some cases of failures not being recorded, while all the successes, being regarded as surgical triumphs, were almost certain to have been recorded. Moreover, it seemed probable that a careful selection of cases had been made. The committee therefore advocated the plan of treatment by injection, and preferably by the injection of Morton's fluid. The report was signed by Mr. Howard Marsh, Mr. A. Pearce Gould, Mr. H. H. Clutton, and Mr. R. W. Parker.

A large collection of drawings, illustrating the usual forms, as well as the most noticeable variations, of spina bifida was exhibited, and the committee especially acknowledged the help which Mr. Shattock had rendered them.

The PRESIDENT said that the report contained a collection of information which could be found nowhere else. He ventured to say that many previous notions would have to be given up when the report became public property.

Mr. GEORGE LAWSON read the report of a case in which he had performed successfully Œsophagotomy for the removal of a plate with three false teeth, which had been accidentally swallowed and was impacted in the œsophagus. The patient, a milkwoman, aged fifty-five, was admitted into Middlesex Hospital on Jan. 14th, 1885, having about half an hour previously swallowed a vulcanite plate with three artificial teeth. Mr. Lawson endeavoured, without success, to remove the foreign body with a pair of long curved œsophagus forceps. An incision about three inches in length along the lower prominent border of the sterno-mastoid muscle was made; the sterno-mastoid and the omo-hyoid with the carotid sheath were drawn outwards, whilst his colleague, Mr. Gould, drew the trachea in the opposite direction, and with his fingers on the right side of the neck pressed the œsophagus towards the incision. The œsophagus was now visible, and the plate could be easily felt with the fingers. A vertical incision was then made in the œsophagus on to the plate, and after some difficulty the plate was removed by dividing it with the bone forceps. No sutures were put into the œsophagus. The superficial wound was then partially closed with sutures and covered with boracic lint charpie, over which was placed carbolic gauze and oil-silk. The patient was ordered to be fed with nutrient enemas and Slinger's nutrient meat suppositories. On the following morning the wound was dressed, and there was found to be a very free discharge of saliva and mucus through it. On the 19th, the fifth day after the operation, some redness appeared around the wound, and this increased for two or three days. This was followed by an offensive discharge, with some sloughs of cellular tissue. On the 20th, the seventh day after the operation, as much of the fluid taken by the mouth continued to escape by the wound, Mr. Lawson introduced an œsophagus tube with a funnel-shaped extremity, which projected about six inches from the mouth. This was kept in, and through it the patient was regularly fed. The tube was worn until February 8th, when, as the wound in the œsophagus was apparently closed, it was removed. During this period the tube was changed about every four or five days for purposes of cleanliness. On February 22nd the external wound was healed, and the patient since then has been able to take her food as usual. She has left the hospital, and is now quite well.—Mr. LEDIARD (Carlisle) contributed some notes on a case of œsophagotomy. The patient was admitted into the Cumberland Infirmary with a tooth-plate in the œsophagus, which had become dislodged from the mouth during sleep some twenty-four hours previously. There was pain on swallowing and emphysema of the neck. Various attempts prior and subsequent to admission failed to remove the plate, which was believed to rest somewhere behind the thyroid cartilage. Œsophagotomy was performed, but nothing was found in the pharynx or cervical portion of the œsophagus; it was believed that during manipulation on the table the plate may have been unconsciously moved from its resting-place, as the mucous membrane of the œsophagus behind the cricoid cartilage was somewhat bruised. The wound healed well. The plate was passed per anum on the nineteenth day, and the patient went home quite well, having been in hospital a month. The plate measured 1½ in. by ¾ in., and had sharp points and a hook at one end.—Mr. T. BRYANT said that no doubt the employment of the tube was a useful form of practice, but he thought that soft rubber tubes, like those used by Mr. Charters Symonds, would be an improvement on the hard tubes. Dr. Lediard's case taught us that we should not be in too great a hurry to interfere in such cases. He knew of the case of a man who passed a large plate with teeth eight days after the plate was swallowed. Sutures should not be put into the œsophagus where there was ulceration.

Dr. COLCOTT FOX read notes on two cases of Raynaud's Disease. A woman, aged forty-one, of extremely nervous temperament, dated the commencement of the disorder from ten years back, but though this was the period when her attention was attracted by pain, it is probable that she suffered from slight attacks for some years previously. In the earlier stages all her fingers continually went "like white wax." This condition of recurrent local syncope gradually gave place to local asphyxia, and the feet became involved. The fingers gradually lapsed into a state of chronic asphyxia, which was intensified by frequent attacks of more severity, often leading to "blood blisters and ulceration." The nutrition of the phalanges has suffered greatly, so that her hands are crippled, the fingers are fusiform in shape, livid, shiny, and withered, the nails variously distorted, and the end phalanges much atrophied and almost immovable. The nose and ears are affected to some extent on exposure. Cold and nerve shocks are ready exciting influences. The second case, that of a man aged fifty-one, was of considerable interest, from the fact that, like one of Raynaud's cases, he suffered from diabetes. His hands were not deformed, but he had suffered for several years from "dead fingers." He sought Dr. Fox's advice for symmetrical gangrenous patches on the skin, which recurred, and later for an attack of asphyxia of one great toe and lower third of the inner side of the leg, and then it was found that he had been attacked in a similar manner, though more severely, in the other toe, and on another

occasion "blood blisters" had formed beneath the end of his toes. Dr. Fox concluded his paper by giving a reference to some cases which have been recorded as scleroderma of the extremities. A woman with the latter disease was shown to illustrate the difference between it and Raynaud's symmetrical gangrene of the extremities.—Dr. BERNARD O'CONNOR referred to a case of symmetrical gangrene associated with intra-thoracic tumour which he had shown during the last session at the Pathological Society.—Mr. HARRISON CRIPPS was inclined to look upon the gangrene of the second case as due to the diabetes. He considered that the pathology of Raynaud's disease might be regarded as midway between that of a frost-bite which was due to local influences and that of senile gangrene, which was almost solely due to constitutional causes. Mention was made of a severe case of widely distributed gangrene; the gangrene affected those parts which were at the very periphery of the circulation.—Dr. BARLOW asked to be allowed to supplement his former paper published in the Transactions of the Society by an account of some subsequent observations of the cases therein recorded. He wished to say something of the important question of therapeutics. He spoke of the use of the constant current in two of the cases. The first case alluded to was that of the man aged forty-two, who first suffered from severe paroxysmal attacks which had gradually become chronic, in which the chief symptoms were pain, coldness, and blueness, followed by tingling. In the autumn of 1883 the treatment was begun. At first one pole down the spine and another on the extremity was the method used as advocated by Raynaud. Later on he used with better results two poles to the asphyxiating part. This was done with the aid of a bath of salt water or by "painting" the part with both poles, which was the simplest and best method. Twenty minutes a day was the time devoted to the treatment, which lasted from August to April, and was followed by most decided benefit, which had been permanent. Shampooing was also advised to be continued, and had been practised before the galvanism, with but little success however. Acute paroxysmal attacks he had also treated by means of the constant current. In August, 1884, he had under his care the case of a girl in whom the asphyxia appeared in the hands and feet, lasted about two hours, and generally came on about 9 A.M. or 5 P.M. There was intense pain, and the feet became quite black to about two inches above the ankle. Drawings of this condition were exhibited. This case, which was treated by repeatedly reversing the current, of the strength of about twenty cells, gave decided results, for during some of the attacks but one foot was treated, and this foot recovered whilst the other remained black as long as in an ordinary attack. Nitrite of amyl was used, but had no influence on the local asphyxia, although the physiological effects were produced. In some cases the use of the constant current locally at the commencement of an attack effectually prevented its development. He suggested that the constant current and vigorous shampooing would prove beneficial in Dr. Fox's first case. He thought the action of the galvanism was simply that of a local stimulus to the circulation.—Dr. COLCOTT FOX, in reply, said in his cases the most severe pain was experienced as the attack was passing off. He did not think the gangrene was due to the diabetes in his second case, which had all the characters of Raynaud's disease.

Mr. WILLIAM ANDERSON read notes of a case of Papilloma of the Bladder. The patient, aged fifty-three, was admitted into St. Thomas's Hospital on August 9th, 1884, with symptoms of vesical tumour of twelve years' duration. The first indication of the disease was an attack of apparently spontaneous hæmaturia in 1872. After the third attack the relapses appeared about four times yearly. The hæmorrhage was for a long time the only symptom, and nothing confirmatory could be educed by investigation of the urine or by vesical examination, except a peculiarly localised tenderness in the region of the trigone on contact with a sound. In June, 1884, a vesical catarrh became superadded. On Aug. 14th the *boutonnière* operation was performed, and a soft flocculent growth was found occupying the region of the trigone, extending upwards for about one inch and a half from the internal meatus, and one inch on either side of the median line. The mass was removed by means of forceps, some hæmorrhage resulting. The progress of the case was satisfactory, and on Sept. 10th, twenty-seven days after the operation, the patient was discharged well, except for a minute perineal fistula and a trace of blood in the urine. He is still in good health. The points of interest in the case were the extremely slow evolution of the tumour, twelve years, and the absence of conclusive evidence of the nature of the disease before the digital exploration of the bladder. Under such circumstances any operation determined upon could only be exploratory in the first instance, but the patient probably owed his life to the surgical intervention. Theoretically it seems probable that relapse would take place sooner or later in a rather large proportion of cases considering the difficulty that must frequently arise in making sure of the complete removal of every portion of the tumour. Bearing in mind also the very slow development of the primary growth in many instances, it might be expected that the signs of recurrence would occasionally be deferred until a very late period. Out of thirty-eight cases in which the nature of the tumour was sufficiently indicated in the report, there are four instances of undoubted and four of probable recurrence, all within a year of the operation. Complete relief is noted in one case for five years up to the date of record; in one for four years; in five for two years; and in four for periods ranging between twelve and fifteen months. In nineteen other cases no signs of recurrence had appeared at the time of the report, but the observations had been limited to a term of less than twelve months. There are thus as yet only eleven cases out of thirty-eight in which is registered an immunity of one year and over, against eight cases in which relapse is noted as certain or probable.

Mr. BERNARD PITTS read notes of a case of Tumour of the Bladder. The patient, aged forty-three, was admitted to St. Thomas's Hospital on September 10th, 1884, suffering from some hæmorrhage from the bladder. He had a blanched and debilitated appearance, and stated that he had been passing blood with his urine for more than two years, and that of late the hæmorrhage had considerably increased in quantity. He had never suffered pain, but had been troubled of late with irritability of the bladder. The urine was offensive, deep red in colour, and contained much clot; microscopical examination showed traces of villi. A perineal exploratory operation was performed on Sept. 15th, and a large pedunculated tumour discovered on the right side, just below the orifice of the ureter. With serrated forceps portions of the softer part of the growth were broken off, but the wire of a strong écraseur was subsequently passed round the pedicle and the whole of the tumour thus removed. The pedicle was about one inch long, and of the thickness of a finger. A soft tube was left in the wound, and removed on the fourth day. The patient made a quick recovery, and on October 7th was passing all his urine the right way. He rapidly regained health, and has had no trace of further hæmorrhage up to the present time. The tumour, on microscopical examination, proved to be a fimbriated papilloma with the usual structure. Some remarks were made on the diagnosis of the case, which depended rather on the prominence of the hæmorrhage as a symptom than on the microscopical evidences in the urine. The probe-pointed gorget was tried but abandoned, and the dilatation of the neck of the bladder was made with an ordinary director as a guide for the finger. There was a good deal of bleeding during the manipulation with the forceps, and the operation would have been less prolonged if the écraseur had been used in the first instance. It was not, however, until portions of the growth had been removed that the extent of the pedicle was discovered. The prognosis in this case was a very favourable one, for by using the écraseur the pedicle was cut off quite close to the wall of the bladder, and the rest of the vesical surface was examined by the finger and found to be healthy.—Mr. R. J. GODLEE considered that it was justifiable to make an incision into the bladder in cases which must inevitably be fatal. He referred to such cases in which it was impossible to remove the whole growth, but the patient's life might be prolonged, and certainly their existence rendered more tolerable, by incision into the bladder with removal of as much of the malignant growth as was possible with safety.—Professor HUMPHRY said, on invitation from the President, that his was the first case of exploration of the bladder that had been done in this country. He had heard that the boy was quite well two or three years after the operation. He had been much struck by the long period of cessation of hæmorrhage in cases of villous tumour of the bladder. He first became aware of this fact by a study of the specimens in the museum of St. George's Hospital. He could not interpret this fact. The multiple character of

the growths was one reason why they were so difficult to cure radically.

Mr. T. BRYANT, in bringing the business of the session to a close, said that he considered that the great function of the Society was to discuss papers; and he thought it should not encourage the reading of long papers. The encouragement of full debating powers was all-important in a clinical society, for such debates served to show some fallacy or to elucidate new facts in the most telling manner.

The following specimens were exhibited:—

Mr. Jessett: A case of Plastic Operation for Epithelioma of Lower Lip.

Dr. Colcott Fox: Two cases of Raynaud's Disease.

Dr. de Havilland Hall: A case of (?) Rheumatoid Arthritis, with nodules on the head and clavicle, probably of syphilitic origin.

Dr. Hale White and Mr. Arbuthnot Lane: A patient with a Cervical Rib.

Dr. A. T. Myers: A case of Raynaud's Disease in a boy aged twelve years, in which the ears were affected, and there was Paroxysmal Hæmoglobinuria. The blood showed signs of disintegration of its red discs.

Dr. Stephen Mackenzie: A Remarkable Case of Nævoid Condition of Scalp, having a configuration very like the cerebral convolutions.

Mr. R. W. Parker: Sacro-coccygeal Meningocele.

Mr. Arbuthnot Lane: Fracture of both Superior Cornua of the Thyroid Cartilage.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

AT a meeting of this Society on March 6th,

Mr. BRUCE CLARKE showed a boy aged nine, who was convalescent from a Compound Starred Fracture of the Occipital Bone, together with a Linear Fracture of the Frontal Bone. Tetanus with emprosthotonos set in on the thirteenth day after the accident. Also a case of Union after Fracture of the Lower Epiphysis of the Humerus in a boy, and a successful case of operation for Strangulated Inguinal Hernia.

Dr. THOROWGOOD read notes of two cases of Peritoneal Abscess following attacks of enteric fever. Case 1 was that of a little girl aged ten years, seen with Dr. Eyre of Forest-hill. The patient's illness commenced about Dec. 2nd with symptoms of true peritonitis; typhoid spots subsequently appeared. Two days after return of temperature to normal a swelling appeared at the umbilicus, which, on being punctured, discharged a large quantity of foul-smelling pus. A drainage-tube was inserted, and beef-tea, tonics, and brandy were given, and, notwithstanding congestion of the base of the right lung, the wound was quite healed by Jan. 17th, and the patient made a good recovery. Case 2 was that of a woman aged thirty, who was admitted into the West London Hospital on Oct. 14th, 1884. The attack commenced on Sept. 27th with rigors, and was followed by vomiting and diarrhœa. Temperature on admission 100·4°; pulse 132. The patient lay on her back with her knees drawn up, and complained of much abdominal pain. On Oct. 17th the right side of the abdomen was very tender, and two typhoid spots were observed. Pea-soup motions; diarrhœa moderate. On the 21st an abscess was opened underneath the jaw, and healthy pus flowed out. The patient seemed to be doing well. On Nov. 2nd her temperature was 101°, pulse 132. A troublesome cough came on suddenly, followed by a copious expectoration of pus mixed with blood. There was dulness, with crepitant râles, at right base. On Nov. 6th the abdomen was noticed to be swollen and distinct fluctuation was felt; abundant purulent expectoration; pulse 150, temperature 101·5°; fluctuation in abdomen became scarcely perceptible after the copious expectoration of pus. Exhaustion set in, and, notwithstanding stimulating treatment and diet, the patient died on Jan. 26th. The source of the pus was the question which presented itself in this case. Suppuration of mediastinal glands was suggested, but there had been no difficulty in swallowing nor any noticeable dulness about either posterior or anterior mediastinum. The fluid in the peritoneal cavity appeared thick and similar to that expectorated. This, with the persistent crepitant râles at the extreme base of the right lung, gave support to the opinion that the pus came from an abscess below the diaphragm. The patient's previous health had been excellent. Nothing was noticed in relation to the liver. The post-mortem examination by Mr. Percy Dunn showed that a large abscess had formed in a sac quite apart and shut off from the intestines on the right side, and had worked its way upwards, perforating the diaphragm on both sides, ultimately finding its way into the bronchial tubes.—Dr. TRAVERS thought that in the absence of internal symptoms the diagnosis of typhoid fever on the strength of one spot was hazardous.—Dr. BENNETT said that though he had seen many undoubted cases of typhoid without spots, he had never seen a case where the spots did not class it as one of typhoid.—Dr. THOROWGOOD said the spot in his case was a typical one, and appeared about the time when the eruption was to be expected (second week); at the same time he was not prepared to say positively what the case was, nor was he enabled to say what the starting-point of the abscess was. No evidence of cicatrisation was found in the intestines.

Dr. HERRINGHAM showed a child aged three years and a half, in whom Hemiplegia had come on fourteen months ago. There was at that time palsy of the left arm and leg, and of the lower facial muscles of the left side, with almost complete palsy of the third nerve on the opposite side. Rhythmical tremors of the left side, increased by exertion, began even before the palsy was noticed, and continued ever since. The right third nerve had now almost recovered, but contraction and rigidity had set in on the left side, and were increasing. The child was in good health, and growing fast; no loss of mental power; never any optic neuritis; nor any history of syphilis or rheumatism. Heart normal. Iodide of potassium, arsenic, and tonics had had no effect. The diagnosis was a lesion in the right crus cerebri.—Dr. BENNETT said he saw this case some months ago, and was one of those who diagnosed the case as one of chorea. He did so again to-night, and his prognosis was favourable.—Dr. THOROWGOOD said that all along his opinion had been in favour of a slight hæmorrhage into the right crus, probably from thrombosis.—Mr. LAWRANCE, the President, said the movements seemed rather convulsive than choreic in nature.—Mr. THOMPSON asked whether the gentlemen who diagnosed the case as one of chorea were aware that complete hemiplegia existed on the right side, and that no improvement had taken place.—Dr. HERRINGHAM said, in reply, that no one who had watched the case had ever thought it to be chorea, nor could he conceive of anyone doing so, unless they understood by chorea "anything that shakes"; here the movements were rhythmic, in chorea they are distinctly not so; again, in no case of chorea of which he had heard had paralysis of the eye, or rigidity, or paralysis without wasting, occurred as here. As to the possibility of the presence of a tumour, he thought the lapse of a year had put it out of the question, as the tendency of cerebral tumours was to a fatal result. Eyesight had been normal all along; and there was no trace of heart mischief.

HARVEIAN SOCIETY OF LONDON.

AT the meeting on May 21st, the President, Dr. T. Morton, in the chair,

Dr. F. H. CHAMPNEYS read a paper on Certain Points in the Diagnosis of Cervical Stenosis. The author described briefly the anatomy and physiology of the cervix uteri; its cavity, its orifices, its secretion. As regards the os internum, it was pointed out that this orifice really belongs to the uterine body, and reasons were given for thinking that its size is variable in the same individual, and that it is not rigid, but undergoes spontaneous dilatation, being under the dominion of uterine polarity. He then discussed the diagnosis of stenosis, and showed that no certain inference could be drawn from difficulty in introducing the sound, because it could not be guaranteed that the sound was passed exactly in the calibre of the canal (though this could be assured in the case of the os externum), and because it might catch in a fold of mucous membrane. The diagnosis could, however, be made if difficulty in withdrawing the sound were experienced, because the instrument then travels of necessity in the right path. The paper concluded with notes of sixteen cases of cervical stenosis observed at St. George's Hospital.—The President, Dr. John Phillips, and Dr. A. Routh took part in the discussion. In answer to questions from various speakers, Dr. CHAMPNEYS expressed his disapproval

of the operation for incision of the os internum on the grounds of the risk to life which it involved. Vaginal examinations of virgins should be avoided as a rule. Nevertheless where necessity demanded an examination, the fact of virginity should not be allowed to stand as an obstacle to the patient's chance of recovery. This should specially be borne in mind in connexion with dysmenorrhœa, which in the author's opinion often laid the foundation of serious pelvic disease.

Mr. H. E. JULER offered some remarks on the Use of the Ophthalmoscope in the Practice of Medicine. Dealing first with the methods of ophthalmoscopic investigation, the author described the three modes of examination known as the direct method, the indirect method, and the shadow test. Among the ocular affections which constantly recurred in ordinary medical practice, and for the safe diagnosis of which the ophthalmoscope was necessary, Mr. Juler referred to albuminuric retinitis, optic neuritis, retinal hæmorrhage, atrophy, tobacco amaurosis, and faulty refraction. The subject was illustrated by numerous diagrams, and by the use of artificial models of the eye. The more recent forms of ophthalmoscope were also exhibited, and their use practically demonstrated.—Dr. SANSOM referred to the use of the ophthalmoscope in children's practice. With a little care and patience it was possible to examine the eyes of most, if not of all, children. Great assistance in matters of diagnosis could thus be obtained. Thanks to this help, he had frequently been able to recognise the existence of hypermetropia, of cerebral tumour, and of renal disease. The extended employment of the ophthalmoscope could not be too warmly advocated.—Dr. Alderson, Dr. Sydney Phillips, and Dr. Culver James also took part in the discussion.

The next meeting of the Society was announced for October 15th, 1885.

EPIDEMIOLOGICAL SOCIETY OF LONDON.

AT a meeting of this Society on April 8th, Norman Chevers, M.D., C.I.E., President, in the chair,

Dr. G. B. LONGSTAFF read a paper on the Seasonal Prevalence of Continued Fevers in London. The author referred to the well-known decrease in the mortality from "fever" in recent years. This decrease, he stated, was mainly under the heads of typhus and simple continued fever; the mortality from enteric fever in London had remained comparatively stationary for the last ten years. Since 1869 no fewer than 4374 deaths had been attributed to simple continued fever in London. Following the method of Messrs. Buchan and Mitchell, the author had constructed a diagram showing the seasonal prevalence of the three forms of fever in London. The data made use of were the admissions to the London Fever Hospital, the admissions to the hospitals of the Metropolitan Asylums Board, and the weekly deaths in London since 1869. The results obtained from these various sources were in the main concordant. Enteric fever yielded a well-marked curve; the disease was least prevalent in late spring and early summer, most prevalent in the autumn. The curve of scarlatina was very similar to that of enteric fever. The small numbers available in the case of typhus did not give such well-marked curves, but such as they were, they were very different from those of enteric fever. The mortality and the admissions to hospital from typhus were at a minimum in July, August, or September; from this minimum they increased to an autumn maximum in October, or more usually in November; they were generally excessive throughout the winter; and another maximum, commonly higher than that in the autumn, occurred in January or February. The fall might be sudden in March, or more gradual, and as late as May. Simple continued fever appeared to be even less influenced by season than typhus; the imperfect curve yielded by it, contrary to expectation, showed no autumn maximum like that of enteric fever. Like typhus, simple continued fever showed a maximum in January or February and a minimum in August or September. The author of the paper considered that the deaths still so frequently assigned to simple continued fever were really due to some other cause, and suggested general tuberculosis, septicæmia, and pneumonia. The figures brought forward showed that the hospitals of the Metropolitan Asylums Board dealt with an increasing proportion of the cases of infectious disease in London; but this increase was steadiest and most marked in the case of scarlatina. In 1884 the proportion of deaths in the hospitals of the Board to the total deaths of the metropolis was 11 per cent. for enteric fever, 19 per cent. for typhus, and 16 per cent. for scarlatina.

Dr. THORNE THORNE exhibited some Plans of Isolation Hospitals which had just been issued by the authority of the Local Government Board, and which are designed to meet the requirements of small and sparsely populated districts in such a manner as to secure the best available separation, both of diseases and sexes, without the need for erecting separate pavilions. One of the plans showed how, under one roof, four beds might be placed so as to secure this end. Special arrangements were also made by which nurses could be provided with bedrooms in the same building without any chance of their apartments becoming infected with ward air. This plan is eminently adapted for securing to small towns of some 4000 inhabitants or less, or to public institutions, the maximum accommodation at the smallest cost. The other plan provided twelve beds instead of four, all under the same roof, but having no aerial communication with each other. The pavilion is not only adapted to towns of some 10,000 inhabitants, but it should always be provided as one of the pavilions where two or more are to be erected, its advantages being considerable where only one or two cases of a disease are under treatment, and also for the purposes of isolating doubtful or special cases.

CAMBRIDGE MEDICAL SOCIETY.

AT a meeting of this Society held on April 10th,

Dr. GROVE (St. Ives) related a case of Recovery after Severe Injury to the Head with Symptoms of Fractured Base. He was summoned at 6.30, on November 3rd, to the wife of a farmer who had met with an accident. She was forty years old, and was always healthy and temperate. She had returned home an hour previously from marketing, and had driven the pony carriage round to the yard, but fell in getting out. She was found with her head lying on the stone step in a pool of blood, which was running out of the right ear; she was insensible, and vomited soon after being removed into the house. When seen she was almost unconscious, but answered in monosyllables when spoken to loudly. The right meatus was filled with blood, which trickled out. She was placed in bed and ice applied to the head. There was no sign of injury to the scalp, the pupils answered sluggishly to light, and the pulse was slow, about 60. The next day she was more conscious, her face was flushed, and the pulse 84; she had vomited several times during the night. The right side of the face was swollen and bruised, and she complained of pain in the head; blood mixed with serum was flowing from the ear. The head was shaved, ice applied, and five grains of calomel were given. The third day she was better, slept more quietly, pulse 96, bowels relieved. On the fourth day, on lifting the eyelid of the right eye, blood was seen freely effused under the conjunctiva, and the day after there was evidently some paralysis of the right side of the face, with diplopia and indistinct vision with right eye, loss of sensation on that side of the face, and complete deafness with the right ear; any movement of the head caused great pain. She was fed on milk for about a month, and the bowels kept well open. The improvement was gradual, and in six weeks she was able to walk into another room. Her condition about four months after the accident was as follows: she is quite deaf with the right ear; the taste is impaired on the right side of the tongue; and the sensation on the right side of the head and face is diminished; the sight also of the right eye is not so good as the left, but there is no diplopia now. Dr. Grove was of opinion that the injury was caused by a direct blow in front of the right ear. The subsequent symptoms were very grave; the severe hæmorrhage from the internal ear and the paralysis, indicating injury to the fifth and seventh nerves, pointed to fracture, probably, through the petrous portion of the temporal bone.

Dr. EARLE (Melbourn) exhibited the Temporal Bone of a Suicide with Bullet Wounds. In February, 1884, he was sent for to see a man who was said to have committed suicide, and he found that he had shot himself in the right ear. The external ear was slightly swollen, and there was some hæmorrhage, but besides this there was little to be noticed. A bullet could be felt with the probe, deep in the

ear, but could not be extracted. He was then insensible, but he partly regained consciousness during the next few days. On the seventh day there was copious discharge from the left eye, and on the tenth day the right eye also became involved, and there was ulceration of the cornea of the left, which ultimately collapsed. There was also slight facial paralysis. On the fifteenth day he died, and a post-mortem examination revealed the presence of two bullets (a fact that had previously been suspected, as two chambers of the revolver were found empty). One bullet was found embedded in the mastoid process of the temporal bone, the other was found at the junction of the squamous and petrous portions of the temporal bone with the great wing of the sphenoid. The inner table of the skull was not pierced, but raised up, and over this the dura mater and pia mater were blackened to about the size of a sixpence; above this there was an abscess in the cerebral substance containing about a drachm of pus. It seemed remarkable that the man could have discharged two chambers of his revolver, with the results already related, with such unerring aim as not to injure the external ear, particularly as the absence of any blackening about the orifice of the auditory canal would seem to indicate that the pistol could not have been held very close. Further, that the bullets did so little damage as experiments with the rest of the cartridges proved that, at the distance of a yard, a bullet would go clean through a three-quarter inch deal board, and even at ten yards would be very deeply embedded.

Dr. EARLE also showed a specimen of Aneurysm of the Arch of the Aorta, which he had removed from a middle-aged man who died suddenly. He had been a patient at Addenbrooke's Hospital under Mr. Laurence Humphry with symptoms indicating a tumour pressing on the œsophagus, but there were no definite physical signs. The aneurysm was in the third part of the arch of the aorta, and had ruptured into the œsophagus by a small ragged orifice.

Dr. BRADBURY exhibited a specimen of Sarcoma of Ovaries, and read the case of a woman, aged thirty-eight, single, from whom the growth was removed. Her condition when admitted into the medical wards on March 7th, 1885, was as follows: the patient was thin and had rather the "ovarian expression," the abdomen measured thirty-five inches at the umbilicus, not uniformly distended but larger on the right side, where a hard swelling could be felt, it was dull to percussion; elsewhere percussion was resonant except in flanks. The lower part of the chest was dull to percussion on both sides, with feeble breathing, more especially on the right side. Urine 1025, no albumen. The ascites and effusion into the pleura increased and the legs began to swell; on March 22nd, there being much dyspnœa, the right pleural cavity was tapped, and 104 ounces of serous fluid drawn off, with temporary relief. The patient died on March 25th. The post-mortem examination showed much ascites, and in the right iliac region was found a large irregularly nodulated hard tumour pushing the intestines aside, and pressing the uterus downwards and to the left side. It was not adherent to surrounding parts, and was evidently growing in the right ovary. The left ovary was the seat of a similar tumour, only much smaller. The uterus was healthy. The peritoneum, especially that covering the under surface of the diaphragm, and the mesentery were studded with hard flattened nodules of small size; similar nodules were found covering the left pleura and lung, and there was much clear fluid in both pleural cavities. A microscopic examination of the ovarian tumours and secondary nodules showed that beneath the outer white glistening capsule was a zone of varying thickness, corresponding apparently to the tunica albuginea of the normal ovary, consisting of lamellæ formed by fasciculi of large spindle-shaped cells. From this zone septa descended into the bulk of the tumour, dividing it into larger and smaller lobules, and finally became lost by blending with the deeper substance. The lobules were good examples of the mixed-celled sarcoma, and some contained remains apparently of small Graafian follicles. All the secondary growths examined proved to be mixed-celled sarcomata. A direct connexion between the pleural and peritoneal growths was seen in the diaphragm, where clusters of sarcoma cells stretched along the lymph spaces between the tendons and muscle bundles and connected the serous sacs.

VACCINATION GRANT.—Dr. James Tily of Chiswick has received the Government grant for efficient vaccination.

THE GENERAL COUNCIL OF MEDICAL EDUCATION & REGISTRATION.

THURSDAY, MAY 21ST.

SIR H. ACLAND, PRESIDENT, IN THE CHAIR.

THE Council went into committee for the further consideration of the recommendations of the Branch Councils. The debate was resumed by

Mr. SIMON, who said that in adopting the proposal of Dr. Banks yesterday the idea of the Council was that the second alternative should be adopted by the student, and that before entering on his professional course he should pass an examination in mechanics, elementary physics, chemistry, and biology. The promoters of the amendment, however, appeared to think that four years should be spent at a recognised medical school. His own view was that as much liberty should be allowed to the student as possible. Could it be gravely asserted that if a man spent six months as an assistant house-surgeon in a good provincial hospital like those of Bradford and Sheffield, or at a lying-in hospital, the time so spent should not be included in the curriculum? The English proposal left room for alternatives of that kind. If too much pressure was put on the student in favour of medical schools, the result might be that the number of students would be altogether out of proportion to the opportunities for practice. Thus several dressers might gather round one patient, and there were stories of two dressers having to attend to one leg between them. The Council ought to call in to the aid of medical instruction as many hospitals and infirmaries as possible. Many of the members of the Council were also members of recognised medical schools, and they should be on their guard against *εἰδωλον*. If a committee of curriers were considering the question of armouring ships they would probably come to the conclusion that there was nothing like leather. He objected to tyrannical regulations. If it were possible to do with an examination without any curriculum at all, he should be in favour of it. The English proposal was as far as it was desirable to go, and he hoped that the amendment would not be pressed.

Mr. TEALE agreed that it was undesirable to rivet the fetters too closely. Each branch of the kingdom should be at liberty to adopt the method it thought most convenient.

Dr. PETTIGREW deprecated the system of pupilage alike for the student, the profession, and the public. A busy practitioner could hardly be expected to give much time to teaching. In a hospital it would be better for the student to have only one case well demonstrated than a great number of cases treated in a general way. He did not think three winter and two summer sessions sufficient. Many instances had arisen of the evils produced by unqualified assistants, and they were calculated to bring the profession into disrepute. He was therefore in favour of Dr. Haldane's amendment.

Dr. HUMPHRY protested against Scotland and Ireland laying upon England a yoke which she was unable to bear. Scotch students might be willing to listen to a hundred lectures on surgery in six months, and to profit by them; but it was otherwise with English students. The details and processes of education should to a great extent be left to the licensing bodies themselves. To the Scotch and Irish mind a pupil was an unqualified practitioner, but in truth he was not a practitioner at all. In many cases it was a good thing for a young lad from school to be placed under a judicious medical practitioner, who could look after not only his studies but his morals. He had himself commenced his studies with a strong dislike to everything connected with the profession, but he was placed under a superior medical practitioner in a town where there was a hospital, and where his abhorrence was converted into an ardent love for his studies. Subsequently he had three years in a medical school, and then had the good fortune to become surgeon to a hospital. At hospitals like those at Brighton and Norwich the student was under first-rate practitioners, and it would be monstrous to exclude work done at such places from the curriculum.

Dr. STORRAR admitted that no better instruction could be given than at hospitals like that at Norwich, and under a good medical practitioner; but the Council's recommenda-

tions were not mandatory, and the bodies might interpret them with some latitude. If, however, the four years' study were not clearly specified, students might devise means for evading the regulations, and parents might do the same from motives of economy. The College of Surgeons and the College of Physicians might be justified in allowing a year to be passed at the hospital at Exeter or Leeds, but that was different from laying down as a principle that four years might mean something less than it really did.

Dr. HAUGHTON thought that the debate was the most important of any in which he had taken part since he had been on the Council. In Ireland there were thirty-two county infirmaries with from forty to sixty beds, and there were also fever hospitals. Many of the most distinguished physicians and surgeons in Ireland had attained high rank after attending those infirmaries, which were recognised by the College of Surgeons. The time spent in a county infirmary was regarded as equal to half the time in a metropolitan hospital; and it was the same at Trinity College if the surgeon at the infirmary was considered competent by medical professors. But Ireland would never recognise apprenticeship to a private practitioner, who could not possibly teach mechanics, physics, chemistry, zoology, and botany. No doubt an exceptional result of private study had been produced in the case of Dr. Humphry, notwithstanding his imperfect education (laughter), but Dr. Humphry would have risen still higher if he had been trained on the Scotch or Irish system (much laughter). He (Dr. Haughton) strongly objected to giving the student permission to spend a year and a half out of the four years as an apprentice.

Dr. HUMPHRY reminded Dr. Haughton that the resolution only referred to recognised schools, not to infirmaries or hospitals.

Dr. SCOTT ORR said he did not think there should be one rule for England and another for Scotland and Ireland.

Dr. DUNCAN said he objected to the English proposal, because it was practically undoing what was done on the previous day. It was absurd to require five years and not to require any more study. He had opposed the five years, not because he objected to that time, but because he thought the motion premature. After all, the Scotch proposal only required thirty-three months out of the sixty to be spent at a medical school, leaving twenty-seven months to be spent elsewhere. That was a most liberal arrangement; indeed, he thought far too liberal. With such an arrangement the provincial hospitals would have plenty of applicants for their offices. With regard to attendance on lectures, he had no doubt that the present movement for a teaching university for London was for the purpose of extending professorial teaching and providing more lectures. English students were as desirous as Scotch students to have more lectures, as he could state from his own experience. At present the lectures on midwifery in London were very meagre. Some courses did not consist of more than twenty lectures, which he considered a mere farce. Some of the students who had attended such lectures in an eminent school had told him that they wished they had never gone to them, as they were not worth hearing.

Dr. Duncan's speech was interrupted by the announcement that the hour had arrived which the Council had appointed for the further consideration of the case of Ebenezer Bryceson. Strangers then withdrew, and the case was considered in private.

On the readmission of the public it was announced that the Council had agreed to the following resolutions:—(*a*) "That Ebenezer Bryceson is judged, after due inquiry, to have been guilty of infamous conduct in a professional respect, in that he has produced to the Royal College of Surgeons of England forged certificates of professional study." (*b*) "That the General Medical Council, though it adjudges Ebenezer Bryceson guilty of infamous conduct in a professional respect, does not, under all the circumstances, now direct his name to be erased from the Medical Register."

Sir H. PITMAN moved: "That the solicitor of the General Medical Council be authorised to take the opinion of such counsel as he may think fit as to the readiest mode of carrying into effect the penal clauses of the Medical Act."

The motion was agreed to without discussion.

Dr. STRUTHERS suggested that, as all the educational business could not be completed at the remaining sittings of the Council, it would be better to take the other business first.

The Council then adjourned.

FRIDAY, MAY 22ND.

SIR H. ACLAND, PRESIDENT, IN THE CHAIR.

The further consideration of the motion and amendment with regard to Recommendation 21 first occupied the attention of the Council. By permission of the Council the amendment was altered to read as follows: "At least four winter and three summer sessions shall be passed at a school or schools recognised by any of the licensing bodies mentioned in Schedule A of the Medical Act."

Dr. DUNCAN, continuing, said that upon coming to London he increased the number of lectures on midwifery from a nominal forty, which was a practical thirty, to between seventy and eighty. The lectures were given every day in the week, and it was the largest midwifery class in England. If he gave 100 or 120 lectures, he was sure students would attend regularly. When the question of midwifery was under consideration about six or eight years ago, two of the most eminent medical lecturers on midwifery in London wrote clamorously for an increase from forty to 100 in the number of lectures. Dr. Humphry's opinion therefore, as to the capacities of English medical students, was not held by some of the eminent midwifery lecturers. The recent movement for a teaching university in London was doubtless partly the outcome of a desire for introducing into London what might be called the Scotch system of education. It would be a very great pity, he thought, if the extension of the curriculum for five years was not utilised in that way. He was satisfied that the apprenticeship system in England and Scotland was only valuable under peculiar conditions. If that system was ever restored, it must be in that modified collegiate method which was practised with great advantage in Edinburgh and Dublin. He should therefore support Dr. Haldane's amendment.

Mr. MACNAMARA said he was surprised to hear the observation of Dr. Humphry recommending the Council to legislate for Scotland and Ireland, and not to attempt to touch England. He wished to say that sitting round the Council table of his College were some of the most distinguished men in medicine, surgery, and midwifery (including Dr. Kidd), all of whom were engaged in teaching, and most of whom had commenced as grinders; and seeing that such men had suggested and enforced the plan of education now pursued in Dublin, it was only natural that the Irish representatives should bring it before the Medical Council. They were assembled not to legislate for one division of the kingdom or another, but to make general laws applicable to all. Dr. Humphry had told them of his own experience in connexion with his residence with a provincial practitioner. He (Mr. Macnamara) might be permitted to narrate some experience of a different kind. On the previous evening he had met a distinguished officer in the army; he had been educated according to the Irish system, and attributed to that method the high position which he had attained. He was an apprentice of his (Mr. Macnamara's), and he said: "After I left you I went to provincial practice as an assistant, and I was so disgusted with it that I resolved to enter Her Majesty's service. The gentleman had a large practice. I used to go round and prescribe for patients, and when I came back I often found my prescriptions altered because the medicines were too expensive. The pupils made up the prescriptions, and that was the experience they had to enable them to present themselves for examination. The practitioner himself taught them nothing because he did not know anything to teach. The students spent part of their time in compounding prescriptions, and the rest of the time in smoking." They could never consent to anything of that kind in Ireland or Scotland. Their duty was to legislate for the United Kingdom, and to provide one system of education applicable to every portion of Her Majesty's dominions. What the College of Surgeons in Ireland did was to allow twelve months in a provincial hospital to count as six months in a metropolitan one; but if a man spent his whole lifetime in a provincial hospital he must still spend four winter and three summer sessions in a recognised medical school. In three towns in Ireland there were not only hospitals but admirable schools, where the student could carry on his studies as well as in Dublin.

Dr. HUMPHRY desired to remind Mr. Macnamara that he had never suggested separate legislation for one portion of the kingdom. The resolution he had supported was that at least one winter and two summer sessions should be passed at some recognised school, but that if either of the three

divisions of the kingdom desired to extend that period it should be at liberty to do so.

Mr. MARSHALL, in supporting Dr. Haldane's amendment, said that, having gone on the line of extending the period of study, the Council would be inconsistent if it did not endeavour to utilise the additional period in the best possible way. It was the business of the Council to take care that students had a good knowledge of the science on which medicine was founded. When men left the schools they rarely returned to them, and it was only the education received in the schools over which the Council could exercise any control. They could not control practitioners, but they could insist on a high-class scientific education in the medical schools of the country.

Dr. STRUTHERS considered that the point at issue was the most important of those that had been brought before the Council. The three years' English system had always been looked upon in Scotland in connexion with the drugging and apprenticeship system, which was the worst feature of practice in England. No doubt the student might learn something from a general practitioner, but would he learn as much as he could at a medical school? The practitioner was a busy man, constantly in the saddle or in his brougham, and the pupil was chiefly occupied in making up prescriptions, learning really nothing of what was inside the body. It was impossible to combine a trade and a profession. According to the English system, a medical man might be tempted to say, "I do not think my patient needs anything, but if I prescribe a dose, it will be 2*s.* 6*d.* or 5*s.* in my pocket." Such a system was degrading. The medical man in Scotland was a gentleman occupying the same position as the clergyman and the lawyer. Was that the case in the provinces in England? ("Yes.") According to his experience it was not.

Mr. SIMON: As much as in any other division of the kingdom.

Dr. STRUTHERS said that apprenticeship was part and parcel of the English system. It had been said that the Scotch graduates were not fitted to be good assistants. The fact was that they were too good to be assistants. They would make bad assistants in the same way that they would make bad grocers' assistants, and in that sense the worse they were the better. The student must begin with anatomy and physiology, and then proceed to pathology, and have some clinical training besides, before he was fit to visit patients. A man might have a thousand midwifery cases and yet be an unqualified man. The fourth year was really the best year for the student, and they could not afford to lose sight of him during that year.

Mr. SIMON said that no doubt amusing stories could be told with reference to general practitioners; and if it contributed to Dr. Struthers' happiness to believe that Scotch graduates were too good to be assistants to English practitioners, they could have no objection to it. But the question was not one of medical apprenticeships. The main question was whether public provincial hospitals should be recognised, or whether there should be a narrow limitation of medical education to a comparatively small number of specially privileged schools. They had no right to say that a medical practice could not be learned in a provincial hospital. His own bias would naturally be in favour of a London medical school, but he objected to a despotic law such as some members of the Council desired to impose. The English proposal was that a certain minimum period should be spent in a particular way; but if any of the licensing authorities desired to increase the period they were at liberty to do so.

Dr. CHAMBERS said he was anxious to extend the curriculum, in order to afford an opportunity to candidates for holding residentships or other medical appointments.

Dr. QUAIN said it was true that a man might get but little good from his residence with a general practitioner, but he might get still less good at a medical school. He believed that Dr. Struthers greatly undervalued the training to be obtained under a general practitioner. As to the value of lectures, with great respect to Dr. Duncan, he did not think very highly of them. He himself took honours at the University of London in midwifery, and never attended a lecture in his life. He could say as much against that kind of education as Dr. Struthers had said against apprenticeship. They wanted to get at results. Let the examinations be duly visited and made complete, and they wanted nothing more. As to whether there should be three or four sessions, he was ashamed to discuss such questions. Medical education was of a most unpractical character. A few weeks ago he visited a patient, and on asking the medical attendant how she was, he replied, "Temperature 100·5°," but he could tell him nothing about the state of the bowels or the urine.

Dr. WATSON said that what they had to consider was the difference between the education given at a medical school and that obtained in the condition of pupilage. He objected to maintain a condition of matters which to his mind was exceedingly bad. To decide upon the briefer period, and to leave it open to the universities and corporations to determine what they would demand, would be an unfortunate step for the Council to take. After all the steps that had been taken by the Council, there was one thing especially needed to elevate the condition of the profession—viz., that the practitioner should cease to be a druggist. As to the education likely to be received under a country practitioner, he considered that it would be worse than nugatory. He had been told by a friend who had been a pupil of a general practitioner in London (now dead), who had a number of ladies of distinction under his care, that sometimes when the medicines were being dispensed he would say, "Lady So-and-so is too well; put a little antimony in her mixture." Nothing of that kind would be likely to occur in connexion with the education given in a public school. Dr. Humphry had given a true picture of his own early experience, but it should be remembered that since that time the profession had undergone a great change. The present days were far removed from the time when one of the duties of a practitioner's assistant was to go body-snatching.

The PRESIDENT, before putting the amendment, said he had heard with some regret more than one humorous description of things that had occurred in former days in connexion with the medical profession. Anyone of his own age could confirm the truth of the descriptions; but he was quite sure some of the most hard-working, wise, and honourable Englishmen were to be found among country practitioners. He had, from accidental circumstances, a considerable knowledge of them in various parts of England, and if he were asked for a typical man of a practical, serious, and benevolent character, he would undertake to produce him from among the general practitioners of the kingdom. He also knew something of the difference between the circumstances of a Scotch and an English practitioner. It was an error to suppose that it was possible for all country practitioners in England to rely upon the quality of the drugs or the skill of the druggist in remote districts. In many cases the medicines could not be properly dispensed if they did not do the work themselves.

The amendment was then put, and carried by a majority of 16 against 5, three members not voting.

On its being put as a substantive motion,

Dr. LYONS moved as an amendment: "That at least four winter and three summer sessions be passed at any school and hospital recognised by any of the licensing bodies mentioned in the Medical Act." This, however, was not seconded, and it accordingly fell to the ground. The motion was then put and carried.

The next recommendation considered was No. 22: "No teaching or licensing body should insist on the student taking more than one course of lectures on any one subject."

Sir H. PITMAN said it was the opinion of the English Branch Council that the recommendation should be omitted altogether; but perhaps it would save time to accept the suggestion of the Scotch Branch Council, seeing that anatomy and clinical instruction were exempted from the general rule laid down.

Dr. HALDANE moved, in behalf of the Scotch Branch Council, that the recommendation should read as follows: "No teaching or licensing body should insist on the student taking on any one subject more than one course of lectures, which should include practical instruction, but practical anatomy and clinical instruction should be exempted from this recommendation." In Scotland, he said, a course of lectures generally included 100, besides 50 as an additional practical course. That number was too great, and involved considerable additional expense to the student. Some of the 100 lectures should be devoted to practical teaching, except in the case of practical anatomy and clinical instruction. A single course, however, in practical anatomy and clinical instruction was not sufficient.

Dr. HAUGHTON said he was willing to accept the Scotch proposal if "surgery" were included in the exemptions.

Dr. HALDANE accepted Dr. Haughton's suggestion, and the motion was modified accordingly.

Mr. SIMON thought that the matter should be left to the

discretion of the schools. He agreed with the suggestion of the English Branch Council that the recommendation be omitted, and he would move as an amendment that that course be adopted.

Mr. MARSHALL seconded the amendment, which was carried by a majority of 11 against 9; and it was also carried as a substantive motion.

Sir H. PITMAN moved that Recommendation 23 read thus:—"The following are the subjects without a sufficient knowledge of which no candidate should be allowed to obtain a qualification entitling him to be registered:—(1) Chemistry, including the principles of the science, and the details which bear on the study of medicine, and the rudiments of heat, light, and electricity; (2) anatomy; (3) physiology; (4) materia medica and pharmacy; (5) pathology; (6) medicine, including medical anatomy, clinical medicine, and therapeutics; (7) surgery, including surgical anatomy and clinical surgery; (8) midwifery, including diseases peculiar to women and to new-born children; (9) theory and practice of vaccination; (10) forensic medicine."

Mr. SIMON seconded the resolution, which was then put and carried.

Dr. HALDANE moved: "That hygiene be added—viz., No. 11."

Dr. HERON WATSON seconded the motion, which was agreed to.

Dr. SCOTT ORR moved: "That mental disease be added as a separate subject—viz., No. 12." He remarked that numbers of practitioners were quite at sea with regard to insanity, although the most appalling consequences might result from their ignorance.

Dr. DUNCAN seconded the motion, which was supported by Dr. BANKS.

Dr. HAUGHTON, referring to the recent trials in Dublin, said on that occasion many witnesses were called, some to swear that the accused was insane, and others that he was shamming. Such a state of things was a scandal to the medical profession.

Dr. HERON WATSON approved of clinical education in mental disease.

Dr. PETTIGREW considered that the subject might come in as a department of medicine.

Dr. STRUTHERS moved as an amendment, and Mr. SIMON seconded: "That the following footnote be inserted:—'It is understood that insanity, diseases of the skin, and other subjects on which special instruction may be given, are included in the above enumeration.'"

Dr. LYONS said that a Bill having reference to mental disease was now in Parliament, and it would not do for the Council to treat the subject as a mere subsidiary matter.

By permission of the Council, Dr. STRUTHERS then withdrew his amendment, and the original resolution was agreed to.

The Council then determined to dispense with Recommendations 24, 25, and 26.

Sir H. PITMAN moved, and Mr. SIMON seconded, that Recommendation 27, chap. 5, read as follows:—"The professional examinations shall be so framed as to secure that the knowledge of every practitioner whose name appears in the Medical Register has been tested in all the subjects of professional education which the Council deems essential—namely, (1) chemistry, including the principles of the science and the details which bear on the study of medicine, and the rudiments of heat, light, and electricity; (2) anatomy; (3) physiology; (4) materia medica and pharmacy; (5) pathology; (6) medicine, including medical anatomy, clinical medicine, and therapeutics; (7) surgery, including surgical anatomy and clinical surgery; (8) midwifery, including diseases peculiar to women and to new-born children; (9) theory and practice of vaccination; (10) forensic medicine; (11) hygiene; (12) mental disease."

The motion was agreed to.

The recommendations that had been passed in committee were now adopted by the Council.

The following report by the Dental Committee was, on the motion of Sir H. PITMAN, seconded by Dr. H. WATSON, received and ordered to be entered on the Minutes:—

"The case of Charles Rudolph Werner (Minutes for May 20th, Clause 14) having been referred to them to ascertain the facts in regard to such cases, the Dental Committee find these facts to be as follows: That Charles Rudolph Werner (registered on December 31st, 1878, as in practice before July 22nd, 1878) was on December 8th, 1884, in the Sheriff Court of Mid-Lothian, held at Edinburgh, convicted of misdemeanour, and thereupon sentenced to six months' imprisonment in due course of law."

The Council then rose for the day.

SATURDAY, MAY 23RD.

SIR H. ACLAND, PRESIDENT, IN THE CHAIR.

The Council reassembled at one o'clock.

Sir H. PITMAN, as chairman of the Business Committee, asked the President what course the Council desired to take in respect to the offence committed by Mr. Ebenezer Bryceson under Sections 39 and 40 of the Medical Act.

The PRESIDENT said that that question of course referred to the entry of the Bachelor of Medicine degree of Cambridge upon the Register. He could not say what course the Council was likely to take with reference to that, but he thought it his duty to apply to the solicitor of the Council to ascertain what, if anything, in his judgment should be done. As soon as his reply was received, it would be laid before the Council; but of course that could not be done during the present sitting.

The Council then resolved itself into committee for the purpose of the further consideration of the reports by the Branch Councils in regard to the General Council's recommendations as to the age at which students should be licensed to practise, and on professional education and examination.

Clause 29: "The professional examinations should be arranged in two divisions, the first division to embrace the more elementary subjects. The first division may be completed at or before the close of the second year of professional study, but the second division not till the expiration of two years after the passing of the first division, nor before the completion of the fourth year of study. The examinations, and the subjects included in each, should be such, and in such order, as may ensure, as far as possible, a due continuity and sequence of study."

Sir H. PITMAN moved the adoption of the English Branch Council's recommendation, although he could not quite agree with it: "The candidate should not be admitted to the second examination till he has passed the first, and he should not be admitted to the third examination till at least twenty-one months after passing the second, nor until the completion of forty-five months of medical study." His own feeling was that the final clause of the existing recommendation was the only one that the Council should adhere to. It seemed to cover all that they desired to lay before the licensing bodies. The Council should confine itself to general principles, and if those principles were not carried out, and they were sufficiently serious to warrant any interference with the privileges of the bodies, it would then be time enough to interfere.

Mr. SIMON seconded the motion.

Dr. HAUGHTON moved as an amendment the recommendation of the Irish Branch Council—viz., that the first two paragraphs of the existing recommendation should be omitted and the last paragraph retained.

Dr. BANKS seconded the amendment, which was agreed to.

Sir H. PITMAN moved the omission of Regulation 30, which specified the subjects to be included in the first and second divisions of the examinations. He said the principle was admitted in the clause just agreed to, and the Council had already expressed the opinion that they should not state in what manner the subjects were to be considered.

Dr. HAUGHTON seconded the motion.

Dr. STRUTHERS thought the Council might define what the final examinations should be, though he did not think they could possibly agree as to the earlier ones.

Dr. PETTIGREW said the Scotch Branch Council entered into the matter very carefully, and divided the examination into three divisions, specifying the subjects. From the student's point of view this was of very considerable importance, and he did not see what harm could accrue from such a scheme as was presented by the Scotch Board.

Mr. MACNAMARA said they could not follow out the recommendations of the Council in Ireland, because their scheme of education involved examination at the end of each year.

Mr. MARSHALL moved as an amendment: "The final examination shall not take place till the termination of the full period of medical study, and should include medicine, surgery, midwifery, forensic medicine, hygiene, and mental diseases."

Dr. STRUTHERS seconded the amendment.

Mr. SIMON deprecated detail, and adhered to the opinion that the original proposal to omit the table was the better one.

Sir H. PITMAN said the subjects laid down were really

those adopted by all the licensing bodies. They might be quite well left out. After all, they were but recommendations, and were not needed, as they had already been adopted.

On the suggestion of the PRESIDENT, the amendment was divided, and the first clause, "The final examination shall not take place till the termination of the full period of medical study," was agreed to.

The second clause, specifying the subjects, was withdrawn; and the first clause, on being put as a substantive motion, was agreed to.

Clause 31, "An examination in the earlier subjects of professional study should take place before the end of the first year of professional study," was omitted; and Clause 32, "The professional examination should be conducted both in writing and orally, and they should be practical in all branches in which they admit of being so," was agreed to.

With regard to Clause 33, "Not less than two examiners should take part in every oral and clinical examination,"

Sir H. PITMAN moved the adoption of the English Branch Council's recommendation, which merely contained a verbal alteration, "Two examiners at least," &c.

Dr. STRUTHERS seconded the motion.

Dr. HAUGHTON said he approved of the recommendation heartily as far as the clinical examination was concerned, but there would be great difficulty in carrying it out with the oral examination. There was great risk of error in clinical examination, and therefore the necessity of having it conducted by two persons; but he did not accept the necessity of having two examiners in an oral examination or examination by papers.

Dr. PETTIGREW said this rule was not made in the interest of the examiners, but of the students, so that they might feel that they were not in the hands of one man.

Mr. MACNAMARA said the opinion of the University of Dublin, as expressed by Dr. Haughton, was quite an opposite opinion to that entertained by the College of Surgeons in Ireland. They heartily concurred in the view the Medical Council had adopted, and had so recast their Court of Examiners that they were now in a position to have two at each oral or written examination.

Dr. MATTHEWS DUNCAN thought it was not necessary in the case of the written examination to have two examiners to read every paper. With regard to the oral, speaking for himself as an examiner, he thought it extremely unsatisfactory to examine alone. It was a question, not of honour on the part of the examiner, but of responsibility.

The motion adopting the recommendation as altered by the English Branch Council was agreed to.

Recommendation 34, "The questions to be answered in writing should be submitted to the whole body of examiners for consideration and revision if desirable, before being proposed to the candidates," was, on the motion of Sir H. PITMAN, omitted.

Recommendation 35: "The written answers should be submitted to more than one of the examiners."

Sir H. PITMAN moved that this should stand as recommended by the English Branch Council: "The written answers should be submitted to at least two examiners."

Mr. SIMON seconded the motion.

Dr. HAUGHTON asked whether it was wise to put on record a number of recommendations which bodies for one reason or another would pay no attention to.

Dr. DUNCAN moved the omission of the clause, which was seconded by Dr. HAUGHTON.

Dr. HALDANE moved as a second amendment the recommendation of the Scotch Branch Council: "That a candidate should not be rejected on any written examination, unless his answers have been submitted to at least two examiners."

Dr. PETTIGREW seconded the amendment.

Dr. DUNCAN said if one or two examiners read the written papers, those one or two did not reject the men; they merely laid them before the Board of Examiners for rejection. He therefore maintained that one was sufficient, and that this recommendation should be omitted altogether, because the papers were there for the whole board to read, and not for two only.

Mr. MACNAMARA said that in Ireland students were rejected on a written examination; but the papers were there to be referred to by the whole board if there was any question about the matter. He was in favour of omitting the recommendation.

Dr. HUMPHRY could quite understand the Council leaving the matter to the licensing bodies; but they were not doing that; they were laying down certain general principles, one being that no part of an examination should be entirely conducted by one person. It was not casting the slightest slur upon the honour of the individual examined, but it was assuming that which they knew to be the fact, that examiners had sometimes particular views which they considered to be of vast importance. This applied to the written as well as to the oral examination; it was all very well to say the papers were before the board, and that they could look at them; the fact was the board did not look at them. He thought no part of the examination should be left to one examiner.

The amendment to omit the clause altogether was negatived.

Dr. Haldane's amendment was then put, and carried by 11 votes to 8. On being put as a substantive motion, it was agreed to by 12 votes to 6.

Clause 36, "Excellence in one or more subjects should not be allowed to compensate for failure in others," was agreed to, with the substitution of the words "other subjects" for "others."

Clause 37: "The professional examinations should be held by the several licensing bodies, except in special cases, at stated periods, to be publicly notified."

Sir H. PITMAN moved the adoption of Clause 37 as amended by the English Branch Council: "The professional examinations should be held by the several licensing bodies at stated periods, to be publicly notified, and if, for exceptional reasons, special examinations be held, the fact, with explanations, should be notified to the General Council at its next meeting."

Mr. SIMON seconded the motion.

Dr. HAUGHTON preferred the existing regulation. The examination should be held at stated times, except in special cases, and those special cases ought to be very grave. He moved that the clause be retained as it already existed.

Dr. PETTIGREW seconded the amendment.

Mr. SIMON said it was felt that in certain cases special examinations would be necessary, and all that the English Branch Council asked was that if they were held they should be specially reported to the General Council. The amendment that there should be no special examination could not be universally accepted, and that being so, the Council desired to have some security applying equally to all the divisions of the kingdom.

Dr. PETTIGREW said if it was known that the professional examination could be held only by the several licensing bodies at stated periods, to be publicly notified, it would take away all excuse for troubling those bodies to grant special examinations.

The amendment was agreed to.

Clause 38: "No university of the United Kingdom should confer any degree in medicine or surgery, whether that of Bachelor, Doctor, or Master, upon candidates who have not graduated in Arts, or passed all the examinations required for the Bachelorship in Arts, or passed, after due course of education, examinations such as are *bonâ fide* academically equivalent to those required for a degree in Arts."

Sir H. PITMAN moved, and Dr. HAUGHTON seconded, the omission of this clause, which was agreed to.

Clause 39: "As a general rule, none of the higher degrees or qualifications in medicine or surgery should be conferred on persons who have not shown evidence of higher professional attainments."

This clause was also omitted.

Clause 40: "In the examinations on several of the subjects of the curriculum—such, for example, as chemistry, including chemical physics, physiology, and materia medica—the licensing bodies should limit and define by schedule the extent of examination."

Sir H. PITMAN moved that this clause be accepted, with a slight verbal alteration, as recommended by the English Branch Council.

Mr. SIMON seconded the motion.

Dr. PETTIGREW moved as an amendment the omission of the clause.

Dr. HAUGHTON seconded the amendment, which was agreed to.

Clause 41 was agreed to in the following form: "In no case should the examination of a candidate in any subject be conducted exclusively by his teachers in that subject in the school in which he has been educated."

Clause 42, "Observation with the microscope should form part of the examinations of candidates for a licence," was, on the motion of Sir H. PITMAN, omitted.

The adoption of Clause 43 was then moved by Sir H. PITMAN as altered by the English Branch Council: "Every candidate for the final professional examination should be required to give evidence that he has had sufficient opportunities of practical study, with care of patients, medical, surgical, and obstetrical, in hospital, dispensary, or elsewhere."

Dr. HAUGHTON seconded the motion, which was agreed to.

Clauses 44 and 45, providing that in examinations in anatomy candidates should understand that they might be called upon to perform actual dissections, and specifying the form of the returns to be made for the licensing bodies, were omitted.

The Council then resumed, and adopted the various recommendations agreed to in committee.

Dr. HAUGHTON moved: "That, in accordance with the recommendation by the Preliminary Examination Committee (Minutes for May 20th, p. 84), the examinations of the Queen's Colleges of Belfast, Cork, and Galway, and those conducted by the Civil Service Commission, be removed from the list of recognised preliminary examinations." The ground upon which this was recommended was because those examinations were superseded by the matriculation examination of the Royal University of Ireland, to which those Colleges were now affiliated. The committee also recommended that the name of the Civil Service Commission be also removed from the list, as their examinations were not fixed at a definite standard, but varied with the service for which they were intended, and also because these examinations were not attended by medical students.

Dr. STORRAR seconded the motion.

Dr. LYONS deprecated taking any step which would bring the Council into collision with the Civil Service Commission, which was one of the most powerful bodies in the kingdom at the present day.

Dr. HAUGHTON said the Civil Service Commission had sent in no answer to the questions forwarded by the Council.

Sir H. PITMAN said the Commission was very much surprised that it came to be put upon the list at all.

Dr. HAUGHTON said nothing could be further from their intention than the idea of giving such a body as that a slap in the face. It was a splendid body, but it did not want to be on their list; and the very fact that it was utterly unable to give the Council the information they wanted, showed that it ought not to be there.

The resolution was agreed to.

Dr. STRUTHERS moved: "That a more complete and continuous system of visitation of examinations is desirable, and that it be referred to the three Branch Councils to consider the subject and to report on it to the Council before its next meeting."

Dr. HERON WATSON seconded the motion.

Sir H. PITMAN said he was rather against pledging the Council to the statement "that a more complete and continuous system of visitation of examinations is desirable," but he saw no objection to the Branch Councils having the subject referred to them for consideration and report. He therefore moved, and Dr. Struthers was willing to accept the amendment: "That the question of a system of visitation of examinations be referred to the three Branch Councils for their opinion, and that they be requested to report to a future meeting of the Council."

Mr. MARSHALL seconded the amendment, which was agreed to.

Notices of motions by Dr. Lyons and Dr. Struthers having been withdrawn, the Council proceeded to deliberate in private upon the report by the Dental Committee with reference to the case of Charles Rudolph Werner, who was on Dec. 8th, 1884, convicted of misdemeanour at Edinburgh and sentenced to six months' imprisonment.

On the readmission of strangers, it was announced that the Council had resolved: "That the Council direct the registrar to erase from the Dentists' Register the name of Charles Rudolph Werner."

Mr. SIMON moved: "That the case of Mr. Bryceson, as regards his having caused himself to be registered as M.B. of the University of Cambridge, though not possessed of the qualification, be referred to the Executive Committee, and that the committee have authority to take, on behalf of the Council, such course as the legal advisers of the Council may advise to be taken, under Sections 29 and 30 of the Medical Act."

Dr. DUNCAN seconded the resolution, which was negatived by 10 votes to 7.

The PRESIDENT said, from communications which he had received, he had no doubt that he should have to summon the Council to an autumn session. He should take steps to ascertain what was the most convenient time. He tendered the thanks of the Council to Sir H. Pitman, the chairman of the Business Committee, and to the Registrar, for the admirable way in which the business had been conducted; and with this the sittings for the present session were brought to a close.

EXTENSIVE AND FATAL INJURIES, WITH FEW AND SLIGHT EXTERNAL EVIDENCES.

To the Editor of THE LANCET.

SIR,—I send you the following case, which occurred at Kingston-on-Thames this week, as showing what extensive and severe internal injuries co-existed with but comparatively trifling outward appearances:—

A coal porter was found in a crouched position on the line of metals in the railway station coal yard, on his knees and elbows, with his forehead on the ground, quite dead. At the post-mortem examination the external appearances were as follows:—There was a not very well marked bruise (i.e., small patches of ecchymosis here and there) in the front of the chest and abdomen, measuring 10 in. by 7½ in.; and a well-marked bruise, under cover of the upper arm, 3 in. from the apex of the axilla, measuring 6 in. by 6 in.; the abdominal wall was protruding about the umbilicus; and emphysema existed on both sides of the abdomen and right side of the chest; the left scrotal pouch was greatly distended. Such were the external appearances; but on continuing the examination the following injuries were revealed. The scalp, bone, meninges, and brain were normal. On examing the chest, numerous small ecchymoses were found, corresponding to the bruises, some also under the sternum and cartilages of the ribs on the left side, and on the visceral and parietal layers of the pleura. The left pleural cavity was filled with fluid blood, containing the spleen (torn in three places); the stomach separated from the gullet at one end and the pylorus at the other, and a portion of the liver about 4 oz. in weight. The left lung was penetrated (the spleen, stomach, and portion of the liver were forced through an opening in the diaphragm, admitting the double fist). The right pleural cavity was filled with fluid blood, containing numerous small fragments of liver, forced through a small tear in the diaphragm. The right lung was much bruised in its upper part; the heart was empty and natural. When opened the abdomen was found to contain numerous small clots and fragments of liver interspersed among the viscera; the major portion of the liver was reduced to pulp, and what remained was traversed by fissures in all directions. Many mesenteric veins were ruptured; four yards of small intestine were forced into the left scrotal pouch, and about one yard and a half into a small pouch in the perineum. The bladder was ruptured to the extent of admitting four fingers, and the symphysis pubis was fractured. The right kidney was torn in three places, and the suprarenal body smashed. The left kidney was bruised, with three extravasations of blood, and the suprarenal body smashed. The aorta was completely ruptured on a level with the fractured spine, and lacerated three inches lower down. The left psoas muscle was ruptured and pulped. The third rib on the right side was fractured in front; and the fourth, fifth, sixth, seventh, eighth, ninth, tenth, eleventh, and twelfth ribs were fractured and splintered in various places, some in two and others in three. The first rib on the left side, close to the sterno-clavicular articulation, and the ninth, tenth, eleventh, and twelfth ribs were also broken. The ligaments of the ninth and tenth dorsal vertebræ were torn across; the tenth dorsal vertebra was fractured across, and the spinal cord and membranes were also severed. The vertebræ on the left lateral aspect from the second lumbar vertebra were fissured upwards to the transverse fracture of the tenth dorsal vertebra. The transverse processes on the right and left of the lumbar vertebræ were fractured, that of the second left lumbar vertebra in two places. The bones of the extremities were sound.

The man had evidently been nipped between the buffers of heavy trucks and dropped on the line, where he was found.

I am, Sir, yours truly,

Kingston-on-Thames, April 28th, 1885. E. M. SHIRTLIFF.

THE LANCET.

LONDON: SATURDAY, MAY 30, 1885.

IT is a notable remark of HUME'S, that the ancient history of England is nothing but a catalogue of reversals; everything is in fluctuation and movement; one faction is continually undoing what was established by another. So it is, *mutatis mutandis*, with the Medical Council, which has just finished one of its longest and least creditable sittings. All its laws are in a state of fluctuation and movement, and with the less excuse, as it is a continuous body, made up for the most part of the same individuals. Nevertheless, its Recommendations are continually being reversed, and a great part of the time of one of its meetings is occupied in undoing the Recommendations which occupied a great part of the time of a previous sitting. The last meeting affords a striking illustration of this charge. No less than seven or eight of the chief Recommendations of the Council were erased, which comes to very much the same thing as reversal. Let us enumerate a few of these Recommendations. We remember that some of them were argued and fought for by some of the best members of the Council, and, if we mistake not very much, some of them have received their quietus from gentlemen who a few short years ago fought bravely for them. But to the actual reversals. If there was one thing more than another that the Council seemed agreed upon not long since, it was that there should be an examination *at the end of the first year*, with the view of giving the young student a sense of responsibility sooner than he is apt to feel it. At the recent sitting this Recommendation was omitted. Perhaps the one point on which there was, two or three years ago, the greatest consensus of opinion was that in examinations in certain subjects, as chemistry, chemical physics, &c., there should be a limitation and definition by schedule of the area or extent of examination. And this limitation was enjoined in Recommendation 40. Recommendation 40 has now been omitted, and henceforth the poor candidate will have no guide in the trackless and vast domain of these wide subjects. A most wholesome Recommendation (22) was passed a few years ago, asserting that no licensing or teaching body should insist on more than one course of lectures on any one subject. The "lecturing" element in the Council has attacked this Recommendation with success, and it is gone, and there is nothing to prevent teaching and licensing bodies exacting an unreasonable attendance on several courses of lectures on the same subject; in other words, an unreasonable amount of fees on every subject in the curriculum. This is the kind of work which brings the Council into disrespect. The reversals which we have instanced, our readers will see, are only specimens; but they are very significant ones, of great moment to medical students. Their moment is increased by noticing how the Council has been extending the curriculum, adding new subjects, and doing its best to add to the time to be spent at a medical school. This may be all right; but it is very unfortunate that such burdens should be imposed by a Council so deeply representative, not of the student or the practitioner, but of examining and teaching bodies, whose interest—we will add whose pecuniary interest—lies in prolonging and complicating the process of medical education. As our readers know, we are not of the number of those who see any immediate prospect of the public being undersupplied with medical men. We have shown frequently of late how ample is the supply of medical students, and how crowded are the ranks of the profession, leading in most places to a competition and pressure which in the professional sphere are not a little unseemly. We have pointed out that this state of matters justifies the Council in any reasonable measures for correcting laxness in medical education, and for improving the quality and methods thereof. But in the positive legislation of the Council there is too much suggestion of mere blind faith in lectures, time, medical schools, &c. On the motion of Dr. HALDANE, the time of study to be required of medical students is no longer three winter and two summer sessions, but "four winter and three summer sessions," and all this to be "passed at a school or schools recognised by any of the licensing bodies in Schedule A of the Medical Act." There is an extensive and a growing impression outside the Council that one conspicuous defect in the education of medical students nowadays is their ignorance of ordinary practice, and that one great improvement would be to require a certain time of the student period to be spent in private practice under the supervision of a private practitioner, whose work would supply cases and experience which are not to be met with in hospital practice. But such practical methods have no favour with the Council, which believes in nothing but the Schools recognised by the infallible nineteen bodies mentioned in Schedule A. How different might medical education be if the Council contained fewer representatives of those charmed bodies in Schedule A, and a few of the representatives of the men that carry on the actual medical practice of the country. Again, Dr. BANKS has succeeded in passing a resolution extending the curriculum over five years. As we explained last week, this resolution was so modified as to be not so formidable as it looks. It was made only to apply to cases in which certain preliminary subjects—elementary mechanics, physics, chemistry, and biology—had not been disposed of before the commencement of strictly medical work; and such cases are supposed to be exceptional. Still Dr. BANKS's motion is the expression of the wish of the Council to extend the length of time spent in medical schools, for which undoubtedly he adduced some powerful arguments. What is to be regretted is the constant change of the Recommendations of the Council, and the fact that the very constitution of the Council gives colour to the charge that the members of it are thinking more of the bodies in Schedule A which they represent than of the poor overburdened medical student who had ten subjects on his back before the recent meeting, and has now twelve, with the prospect of five or ten more if some other Council be not devised, or some other method of using the time and money of the present one. One resolution of much interest, proposed by Mr. MARSHALL, was passed—viz., to appoint a small committee, consisting of Dr. HALDANE,

Dr. A. SMITH, and himself, to superintend the preparation of statistical returns relating to the medical profession. The Council has the materials of such statistics, and it has the money to have them analysed and certified. We have seen lately how much the facts about the profession may be misstated, to the great detriment of it and the public. We feel thankful to Mr. MARSHALL for his resolution, and expect to feel much more so for the work to which it commits him and his colleagues—two gentlemen very likely to prove useful co-operators, and one of whom, Dr. AQUILLA SMITH, has already done good work of the sort.

THE paper which Dr. ANGEL MONEY read at the meeting of the Royal Medical and Chirurgical Society on Tuesday last was an original contribution to experimental pathology, having an important bearing on clinical medicine. The investigation clearly showed that a great variety of clinical phenomena could be brought about as the result of embolism of the capillaries of the spinal cord and brain. Dr. MONEY went further than this, and generalised to the effect that any symptom or group of symptoms could be caused by obstruction of the smallest bloodvessels. It is not improbable that the generalisation will be found to hold good. Indeed, as was argued by the author of the paper, the number of symptoms observed in the experimental investigation was sufficient to defend the position which had been taken up. Sudden death, cerebral and spinal paralysis, simple twitching, rhythmical twitching, choreoid movements and the so-called *mouvement de manège*, movements of rotation, and other forms of these "forced" or "uncontrollable" movements, were all observed as immediate effects of the introduction of granules of starch into the arterial circulation. Many of the symptoms were observed in one and the same animal. The most important observation which Dr. MONEY claims to have made was the occurrence of a succession of different movements, such as could not, allowance being made for the anatomical difference between animals and man, be distinguished by him and several other gentlemen from the movements of human chorea. There is almost overwhelming evidence of the dependence of most cases of chorea in the human being on disturbance primarily in the *brain*, but it is by no means certain that chorea may not be caused by lesions situate lower down than the basal ganglia. And the experiments were held to prove that in the cat and guinea-pig these choreoid movements were the result of nervous discharges originating in the nerve-cells of the spinal cord. The evidence on this point appeared to be conclusive. In a cat the abnormal movements were limited, roughly speaking, to the upper half of the body, the reflex actions were greatly exaggerated over this area, and the autopsy showed the granules of starch only in the vessels of the upper half of the spinal cord. There were no movements and no exaggerated reflexes in the lower half of the body, and no emboli in the lower half of the spinal cord. Emboli were widely scattered in the brain in the same cat, but that the cerebral lesion was not the cause of the choreoid movements seemed to be proved by the foregoing and following considerations. When in another cat the emboli were shot up the internal carotid artery and only reached the brain, no choreoid movements occurred in the limbs or trunk, and there was no obvious alteration in the state of the reflexes. Dr. HUGHLINGS JACKSON, in the course of the discussion, remarked on the importance of the discovery that irregular movements, of no matter what kind, might be caused by capillary embolism. He also argued that in the cat and other animals, whose cerebral and muscular structures were very different from those of man, it was impossible for the varied movements of human chorea to occur, for the reason that these animals did not possess the mechanism for the production of such movements. The question remains, "Does human chorea ever result from capillary embolism?" Dr. HUGHLINGS JACKSON, Dr. BROADBENT, and the author of the paper are of opinion that some cases of chorea may own this causation. Several pathological observations have been recorded tending to prove this point; but it must be confessed that until we have in our possession a series of experimental investigations on the nervous system of such animals as monkeys, whose nervous system approaches nearest to that of man, the question must remain unsettled.

WE invited attention in a recent number to a company which had been proposed for insuring lives without the assistance of the members of the medical body as advisers on the question of the life of the insurer. We now direct the notice of our readers to certain other proposed or *de facto* companies, in which not the life exactly but the health of the assured is provided for. It would appear that there are at the present time no fewer than three of these last-named companies before the public in competition for favour. The first of these is called the Medical Attendance Assurance Association; the second, the Health Assurance Association; the third, the Sickness and Accident Assurance Association. The object professed by the Medical Attendance Assurance Association is to indemnify its insurers against the expense of providing adequate medical attendance for themselves or their families during illness resulting from disease or accident—the insurers, subject to mere nominal restrictions, having the option of selecting their own doctors. This is the first part of the programme; but there is a second, in which it is provided that the company shall indemnify, by weekly allowances or compensation, those whose source of income fails during illness, or shall recoup these persons the loss accruing through having to employ a substitute during illness to attend to their duties or business. The other two offices embrace in their plan the latter part only of the above. They propose to recoup the sick for losses sustained during sickness; and the Sickness and Accident Office, as its name implies, takes up accidents as well as ordinary illnesses. With both these last-named offices medical attendance is, so far as we can see, self-provided. The sick select and pay their own medical advisers.

The idea of an insurance for sickness amongst the richer classes is not altogether novel, although it has never yet been carried out to a sufficient extent to prove its value or its success. But practically in the sick club system the scheme has been tried amongst the working classes. In most of the sick clubs the provision for medical assistance is secured by the services of one medical man for one club. But there are, or if there are not now, there have been

clubs in which the patient has had the right of selecting his own doctor, just as is suggested in the Medical Attendance Assurance Office. In this experience, therefore, we find the test of the whole subject. Again, we find the test of the whole question in those dispensaries in which the subscribers have the right to make their own medical selection. We are not prepared to say that the system which in these cases is in practical operation is always bad in its working. In some instances we must acknowledge that it acts fairly well. There are, however, elements of success in such instances which do not exist when the wealthier classes of the community come under the experiment. In the poorer classes the rate of fee for medical assistance is at one and the same time very moderate, and taking it all in all very uniform. In plain terms, the sick adopt the plan because it respectably suits their modest means. They could not easily get the required advice more cheaply if they were not subscribers to the club or dispensary; and they understand that, under the advantage of the system, they are obtaining, often from the same practitioner, the self-same benefit as other and wealthier patients obtain at a much higher cost. Therewith they are satisfied. If they were rich they would not be satisfied, a fact which is proved every day from the well-known circumstance that as men rise in the social scale they pass in the doctor's books from the dispensary or club book into the private book.

In forecasting on the scheme of the first-named new company, we have to ask if it is probable that patients who can, if they will, pay any reasonable fee to any physician, surgeon, or accoucheur, will consent to tie themselves to a method the whole success of which will depend either on a levelling system of payment or on the introduction of a third or middle agency between the sick man and his skilled adviser. We consider that the forecast is not favourable to the scheme, but if we should prove to be wrong, our mistake will be succeeded by a social change in medicine, a socialism which in a few years will bring about an entire revolution, leading probably to the abolition of fee-taking and book-keeping altogether, and to the institution of an order of practitioners remunerated by districts or communities in fixed annual stipends, and bound to give their services to all who summon them. The club doctor in high places, receiving an annual income in quarterly payments, will then be *Fortunæ filius;* and the electrical attraction of the gold and silver piece wrapped in mysterious envelope and handed with more mystery, will remain only as a memory.

OPINION as to the best mode of treating the wound left after amputation of the mamma, is much divided just now in Paris, opposite views being firmly held by surgeons of equal eminence and experience. On the one hand, we have a school led by M. VERNEUIL, teaching that no attempt whatever should be made to secure healing by primary intention, but that the large wound left after free removal of the breast and of the axillary lymphatic glands should be allowed to close by granulation. In support of this view they allege that when the operation is properly performed it is impossible to secure union by first intention, and that the attempt to do so induces surgeons to narrow the limits of the operation, and so to render recurrence of the disease more certain and more rapid. They further assert that the opposite practice is dangerous, as it increases the liability to erysipelas and other forms of blood poisoning, and that the time taken for the final healing of the entire wound is not at all, or not materially, diminished. On the other hand, we find MM. TRÉLAT, CHAMPIONNIÈRE, and POLAILLON representing another school, and holding equally firmly that as a rule union of the wound by first intention is not only the quickest but the best mode of healing in the majority of cases, and that when properly carried out, after a carefully planned and executed operation, it does not expose the patient to risk of local or general poisoning, or increase the danger of recurrence of the malignant neoplasm. When views so divergent are expressed by such high authorities upon a line of practice very common in the experience of all operating surgeons, a careful consideration of the question is demanded by all engaged in this department of practice. As in other similar cases, we should expect to find much of truth on each side.

Three points are to be considered in operating for cancer of the breast: the successful removal of the disease, the safety of the operation, and the speedy restoration of the patient to health. The relative importance of these points depends upon the view that may be held of the value of the operation. If it be held that it is impossible or impracticable so to operate as to prevent altogether, or to postpone for more than a short time, recurrence of the disease—if, in other words, the advantage of the operation be slight, then the certainty and speed of recovery from the operation become of greater relative importance than in the opposite condition. Where the possible advantage to be gained is great, the price to be paid for it may not unreasonably be increased. When we apply this test to amputation of the breast we find that while the success of the operation in retarding or preventing recurrence is only too small, yet it is such as to justify the surgeon in asserting that in well-selected cases he may hope to postpone recurrence of the disease for many months or years, if not permanently. From this point of view the thoroughness of the operation becomes the chief aim of the surgeon, in comparison with which the other considerations named are of secondary importance. Where, on the other hand, in more advanced cases of disease, the utmost that can be hoped for is an amelioration of the patient's condition and a short respite from the ravages of the disease, the severity of the operation assumes serious proportions, and the value of any means that render the safety of the patient greater and her recovery more rapid is proportionately increased. In cases that are favourable for the operation the parts should be very freely removed, all outlying portions of the mammary gland being carefully sought for, and the axillary glands, even when not palpably affected, excised. About this all surgeons are agreed, but it is necessary to insist upon the thoroughness of the removal as shown by the time elapsing before the reappearance of the disease as the one test by which success or failure of an operation is to be judged. The surgeon must decide in each case how the operation is best to be planned, and it is wrong to lay down any rule as to the extent of skin or other tissue to be removed, different cases

requiring quite different treatment in this respect. But this imperative demand for free removal of the disease having been met, and the wound inflicted, the question arises whether there is any reason why one method of healing is to be preferred to another. It is no doubt true that great care and attention are needed to secure healing by first intention, but there is also no doubt that in many cases such care and attention are rewarded with complete success, and that the period of convalescence is rendered considerably shorter than under any other mode of healing. And unless the surgeon neglects making proper provision for drainage, and fails to protect the wound by a thorough use of antiseptics, he does not expose his patient to the danger of erysipelas and other infective wound diseases. Nor is there any *a priori* pathological reason why healing by granulation should be preferred to that by primary adhesion. The resemblance between the cancer cell and the rapidly formed and growing masses of protoplasm found in granulation tissue is an argument in favour of healing by first intention where the amount of lymph effused is reduced to a minimum, and where also the vascular hyperæmia is less and of shorter duration than in healing of a large wound by granulation. The influence of hyperæmia upon the growth of cancer is well known, and should the surgeon leave behind in his wound any cancer "germs," or cells prone to take on the cancerous development, it is in accord with pathological doctrine and clinical experience that prolonged hyperæmia and abundant cell growth of low type might stimulate the germs or disordered cells, and lead to a rapid recurrence of the disease. While, therefore, we cannot but think that the doctrine of M. TRÉLAT is sounder than that of M. VERNEUIL, we fully endorse the latter's caution, that, in attempting to secure rapid healing of his wound, the surgeon may consciously or unconsciously lessen the extent of tissue removal, and so sacrifice the greater to the lesser good. We would state the matter thus. In planning and carrying out his operation the surgeon should think only of the wide and efficient removal of the disease, without regard to the mode of healing of the wound; but having made the wound, if he finds it practicable to obtain healing by first intention, he should certainly direct his efforts to that end.

THE *furore* excited by Dr. FERRAN'S alleged protective inoculation of cholera continues unabated, or rather with increasing ardour. Last week it was reported that he had operated upon 8000 persons in Valencia alone, including two Madrid doctors—MORENO and TOLOSA—who thereby became converts to the new doctrine. It is also stated that four hours after their inoculation they experienced the cramps, diarrhœa, fever, and delirium of cholera, and that after sixteen hours "they were all right again." Further proof of the efficacy of the measure is cited from the Alcira Hospital, where all the inmates were inoculated, with the exception of two, who declined to submit to the operation. Cholera attacked these two recalcitrants, and they succumbed to the disease. In the face of these and other facts, Dr. CAMERON did well to ask the Secretary to the Local Government Board whether he would consider the propriety of nominating a small commission to visit Alcira and report. He stated that Dr. FERRAN was desirous that an English Commission should be appointed to verify his results. Mr. RUSSELL, in his reply, promised to bring the proposal under the notice of the Secretary of State for India; but we venture to think that it would be better to send the Commission from England, as the question is one which directly involves the subject of choleraic micro-organisms that have been so much studied by a few of our scientists. It may be remembered that Dr. FERRAN adheres to the bacillary doctrine of the etiology of cholera, but that he declares that KOCH'S comma bacillus is but one stage in the development of an organism, whose germs he avers to have discovered. Although we are unwilling to condemn on *a priori* grounds a discovery of such moment as this would be if verified, we are yet very reluctant to admit that such vaccination can protect from true cholera, or to see in the results as reported anything more than coincidences. Asiatic cholera is not prevalent in Alcira, nor, so far as we know, has it reappeared anywhere in Europe this year, and therefore the conditions of a crucial test are wanting. We are not surprised at the excitement that has been caused by the announcement of the alleged prophylactic; for the history of epidemics of this disease shows how much the people dread its invasion; and they would willingly submit to any measure that promised them immunity from the plague. It is significant that at the recent conference at Berlin not even Dr. KOCH himself as much as hinted at the possibility of a protective vaccination amongst the measures of meeting the disease; and FERRAN'S work was only cursorily mentioned by one speaker, Professor VIRCHOW, who believed that the various forms described by FERRAN were the results of disintegration of the bacilli, and not stages in their evolution. The matter has, however, reached a stage in which it ought not to be disregarded without a full and sufficient investigation; and although we doubt very much the possibility of arriving at any satisfactory conclusion except in time of epidemic, it is very desirable that Dr. FERRAN'S labours should be submitted to such an examination by competent and trustworthy authorities. We fully approve of the step somewhat tardily taken by the Spanish Government in prohibiting any further inoculations until such inquiry has proved the efficacy of the measure. For if the whole thing be proved fallacious, the task of dispelling the delusion will be the greater the larger the number of the inoculated; and if it be shown to be really efficacious, no harm will be done by deferring it until this is proved. The position of Dr. FERRAN is a difficult one; for, although he has acted in good faith, he must either be a misguided enthusiast who has pushed his conclusions far beyond their legitimate limit, or a great discoverer. Pending such an inquiry it would be unfair to judge him, but we cannot refrain from once more pointing out that to rely upon "protective vaccination" and to suffer the continuance of those insanitary conditions that favour the spread of cholera would inevitably lead to disastrous results. Nor is it possible to view with equanimity the prospect of an application of these inoculation measures to other specific diseases, an extension which would be sure to be attempted if Dr. FERRAN were proved to be in the right.

DR. WILKS has accepted the invitation of the Council of the Midland Medical Society to deliver, in November, the inaugural address of the session 1885-6.

Annotations.

"Ne quid nimis."

THE COLLEGE OF PHYSICIANS AND THE CROONIAN TRUST.

IT is but seldom that a medical corporation is troubled with an *embarras de richesses*. But this is the peculiar good fortune of the Royal College of Physicians at the present time. In 1706 Dame Mary Sadlier founded the "Croonian Lectures," and instead of the amount of the modest fee which has hitherto been paid to the lecturer the College finds itself in possession of the annual sum of £207 net under her bequest. It is obvious that no such sum can be devoted to a course of lectures for which £10 has previously been found a sufficient remuneration. The College therefore recommends that application be made to the Court of Chancery to vary the deed of settlement, and the Council recommends the following scheme for the consideration of the Fellows:—

"That the present 'Croonian Lectures' be continued with a salary of twenty guineas, being double that which it is at present. That the residue of the income from the trust, after payment of the Croonian Lecturer, be invested to form a fund for the establishment of a Professorship of Anatomy and Physiology, the person holding such professorship to be called 'The Croonian Professor of Anatomy and Physiology,' and to hold such professorship for five years. That the appointment of such professor, who shall deliver such lectures as the College shall determine, be made within a period of five years from the decree of the Court."

Several Fellows have proposed amendments which would limit the tenure of the professorship, and would bring before the College any new researches, not only in anatomy and physiology, but also in therapeutics and pathology; and we can have no doubt that, in view of other lectures at the College of Surgeons and the University of London, the Fellows will expect a wider departure than is suggested by the Council, and one that will not compete with the usual lectures now annually given in London. A five years' professorship is absurd, when we consider the rapid increase in our knowledge, and the varying lights in which such knowledge may be put before our profession. In fact, we would ask, Could not the large increase in the trust fund be better used than in endowing another lectureship, if twenty guineas were paid instead of ten for the annual course now given? A more detailed and comprehensive scheme than that which is under consideration would be preferable to a hasty decision in the direction of an increased number of lectures, which would be attended by but comparatively few Fellows or other members of the profession.

THE PENAL ACTION OF THE MEDICAL COUNCIL.

A LARGE part of the time of the Medical Council is taken up with judicial duties. While so occupied reporters are excluded, and only very limited information is afforded as to the grounds and arguments on which the judgment of the Council is founded in any given case. This is to be regretted in some respects. Courts of judgment, like courts of law, should, in general, be open courts, alike in the interest of those judged and of the profession to which they belong. The Council has erased from the Medical Register four names of medical men, as will be seen in our reports, and one name from the Dentists' Register. As far as we can gather, it is impossible to accuse the Council of severity in these cases. There is one great defect in the legal position of the Council as regards cases of misconduct. It has no power to deal with conduct otherwise than "infamous," and it has only one punishment to inflict—viz., the supreme one of removal from the Register. There is much misconduct, to which the word "infamous" could scarcely be applied. And it is in the highest degree to be regretted that the Council has not power to take cognisance of conduct that is unprofessional rather than infamous or against the public interest, and to censure, or apply degrees of punishment less than that of the capital measure of erasure. The medical authorities in Schedule A, indeed, or some of them, have such powers, but they are sorely hampered in using them, so that some who hold their diplomas go from one degree of unprofessional conduct to another with apparent impunity, till at last they outrage public law or morality and incur the one great punishment of disqualification and consequent erasure. One word of kindly warning at an early stage from the Medical Council, or from the body to which they owe their diploma, might have saved them. But it is withheld, and so it comes to pass that half the time of the Medical Council is taken up with examining gross cases of infamous conduct, and no attempt is made to deal with hundreds of instances of unbecoming and unprofessional conduct. It is not so in other professions, as was well pointed out by a correspondent last week.

THE REPRESENTATION OF THE EDINBURGH AND ST. ANDREWS UNIVERSITIES.

SIR LYON PLAYFAIR has rather abruptly intimated his intention of not offering himself at the next election as a candidate for the representation of the University of Edinburgh. We do not forget the part that Sir Lyon Playfair has played in hindering medical legislation and in misleading the House of Commons with erroneous statistics of the profession. In view of this action, we cannot pretend to regard his withdrawal from the post which he fills with unmixed regret. The large medical element in his constituency, and his supposed relation to the profession, gave more serious importance to any such action on his part. We are little concerned with the political bearings of the step taken by Sir Lyon Playfair. But we will take the liberty of hoping that the seat will not be wasted on some aspiring lawyer, who is always ready to profit by such opportunities. Parliament is full of lawyers, and it is conspicuously deficient in representatives of science. We commend to the constituency of the metropolitan University of Scotland the claims of science, and urge them to elect a man who will worthily represent it, and who will magnify the university by recognising in it a national institution, which exists not for Scotland's benefit alone, but that of the empire. The Scotch universities have sometimes acted as if they were parochial institutions, with all the jealousy of public criticism and check which such institutions are apt to feel. The election of a great public man, one who by science or by statesmanship has shown himself to be above mere party politics, will be creditable to the University and advantageous to the State.

POSITION OF THE FŒTAL HEAD AT TERM.

As an inaugural thesis in the University of Dorpat, L Brühl has published some observations on the position of the fœtal head and the extent of its entrance into the pelvic cavity at term. In primiparæ the greatest circumference of the head was found to have passed the brim at the end of pregnancy in half the cases. In multiparæ it only reached the pelvic cavity in a fourth of the cases. The reason of the difference is to be found in the greater elasticity of the abdominal wall and of the uterine ligaments in primiparæ. In contracted pelves, where the conjugata vera measured less than ten centimetres in primiparæ, the head entered the

cavity in only a third of the cases, the greatest circumference in scarcely any passing the brim, and in subsequent pregnancies the position of the head became higher more rapidly than was the case in normal pelves. The prognosis of labour depending upon the relation which exists between the fœtal head and the maternal passages, it is the practice in Berne, where these observations were made under the supervision of Professor P. Müller, to grasp the fœtus through the abdominal wall and force the head as far as possible into the pelvic canal at the completion of pregnancy. Generally, when the head has more than half entered the pelvic cavity one can predict that birth will take place naturally. On the other hand, it is by no means necessary to infer that instrumental interference will be required in all cases where the head has entered the canal to only a slight extent.

THE HOMES OF THE POOR.

THE publication of the Report of the Royal Commission on the Dwellings of the Working Classes brings more prominently to public notice the relation of vestrymen in London parishes to insanitary tenement houses. We read of a recent meeting of the Clerkenwell vestry, at which a complaint was received through the Local Government Board of the condition of certain premises in that district belonging to a vestryman, and that complaint had been made to the vestry and no action taken. In the course of the discussion it was stated that "several vestrymen made a good livelihood by being house-farmers." There may be no objection to the owners of tenement houses being represented in due proportion upon the local authority, but where officers hold their appointments entirely at the will of people of this class it becomes obvious that they are likely in some cases to be deterred from carrying out their duty. If tenants could obtain damages against their landlord for injury to health, the result of living in an insanitary dwelling, there would be less need for the interference of the sanitary inspector; but this is not possible except where a previous guarantee has been given that the house is in proper sanitary condition. In a recent action for rent in the Clerkenwell county court the defendant denied his liability to pay on account of the insanitary condition of the house, and gave a melancholy account of its defects. The verdict was necessarily for the plaintiff, but the judge expressed his disapproval of the plaintiff's conduct in letting so faulty a dwelling by declining to award costs. An appeal here to the local authority should have been sufficient; but, as the judge said, "It seems from the inquiries of the Royal Commission that public bodies will not put the law in force." The immediate remedy is obviously in the hands of the public, who have it within their power to return as vestrymen those who are more interested in seeing the law carried into effect than evaded.

DR. BRADLEY'S CASE.

WHY does the Home Secretary maintain such silence after the influential petition presented to him on behalf of the convict—a petition signed by "more than one thousand physicians and surgeons"? We have repeatedly drawn attention to the unsatisfactory verdict returned by the jury. In the interests of justice we join in the request—nay, the demand—for an immediate impartial inquiry into the merits of the case. Apart from the fact that many of the alleged acts by Dr. Bradley given in evidence at the trial were physically impossible of accomplishment, there is reasonable ground for declining to accept the theories of the prosecution as regards the main charge. In some cases clemency on the part of the Crown implies a want of belief in the *bona fides* of the witnesses by whose testimony the conviction was obtained; but here no such alternative supposition is necessary. The prosecutrix was shown to have suffered from epilepsy, and to have inherited a tendency to neurotic taint. What more likely, then, that imaginary wrongs were conceived by her during a transient aberration from normal innervation, and afterwards registered in her mind as accomplished facts. From whatever standpoint the merits of this unfortunate case are viewed, the same conclusion is inevitably arrived at—viz., that the conviction was utterly unwarranted by the evidence. We do not plead for mercy, but ask for justice. Here is a man who, previous to this fatal incident, bore professionally a spotless character, and is that character to be destroyed by a mere legal technicality? If the necessary scientific knowledge is not possessed by those who have the issue in their hands, in the name of common sense and public duty let those who understand such matters be left to decide whether Dr. Bradley shall be restored to his friends or finish his fearful sentence of "two years' imprisonment with hard labour." In the event of Sir W. Harcourt still refusing to reply to the appeal long since lodged with him, we pray that he may be moved to action by the general body of the profession.

ANTI-VACCINATIONISTS AND THE GORDON MEMORIAL.

THE Committee of the Gordon Memorial Fund have given evidence of shrewd judgment and sincerity in their reception of an offer lately made to them. The report reaches us from Leicester that a lady expressed her wish to hand over to the committee a house with adjacent grounds, to be used as a home for boys subject only to the proviso that vaccination should not be an essential to admission. The proposal was declined. This lady no doubt meant well, and she naturally feels aggrieved that her principles are not to be accepted along with her gift and its benevolent motive. She is clearly one of those who regard vaccination as a tyranny, fruitful of disease which cannot possibly have arisen otherwise than as stated by anti-vaccinationists, as a useless measure, and a law which it is right and lawful to break. The committee, however, think otherwise, and we venture to say that in their present action they will have the support of all who are in possession of the facts on both sides of this important question. No blame can be assigned to them for the loss of the memorial home, however regrettable that may seem in the interest of the poor. General Gordon's own abundant charity would never have sanctioned even such a gain at the cost of conscience, and the committee, in refusing the responsibility for lives which they could not protect in case of illness, have only followed the example of his enlightened rectitude.

CORPORAL PUNISHMENT AT SCHOOLS.

THE relationship between cause and effect is in many cases notoriously difficult to establish by logical proof, however clear it may be in its *primâ facie* aspect. The tendency with all of us is to seize upon the latest antecedent circumstance, and to assign to it the credit of causation. A case in point is afforded by an inquest held a short time ago at Sittingbourne. A delicate boy, eight years of age, died a few days after having received a whipping at school. The symptoms which preceded death were those of meningitis, with convulsions, and post-mortem examination verified the presence of this disease. Mr. T. Smith, the surgeon who attended the child, could see no clear connexion between the fatal disease and the whipping, but allowed that the shock of the punishment might possibly have had some effect in determining the course of the illness. The jury found a verdict accordingly, but severely censured the schoolmaster for cruelty. We do not approve of severe

bodily chastisement for children at school, but it seems to us nevertheless that a somewhat forced connexion has been established in this case between the punishment inflicted and the disease which was afterwards observed. Inflammation of the brain membranes is one of the most deadly enemies of child-life, and is far more apt to appear as the climax of an undefined constitutional delicacy than as a consequence of injury. Dormant in many children from their inherited feebleness, its chief provocatives are recognised by all practitioners to be want of nutritious food, fresh air, and exercise. It may well be that the weakly child in the present instance owed his death to these commoner evils rather than to his master's harshness. We do not learn that he was beaten about the head, though at the same time it seems clear that the rod was used with more than necessary freedom. The lesson, however, which is most apparent from the facts is that there are young children in school-training for whom their discipline and tasks are equally excessive, and who are, as they stand, unfit to be at school at all. Usually ill-health can be detected by a careful parent before this stage is reached, but it does not necessarily afford such proof as to have allowance made for it under our compulsory educational system. The jury's finding of cruelty, which may have been fair enough in itself, falls short, in our opinion, where it fails to recognise that work as well as punishment should be light in the case of weak children, and that hunger and fatigue may sometimes cause as much injury to health as positive hard usage. Already measures of reform are on foot in many schools. Cheap and good food and recreation hold a definite place in their management; and we may soon be fortunate enough to note a decline in the cramming system, and the adoption of some plan of efficient medical supervision.

VICTOR HUGO.

THE typical Frenchman is dead, and Paris—ay, France; Paris is France—honours his obsequies with bombast and blood. This genius, for Victor Hugo was a genius, and of a very exalted order, played the *rôle* of Chorus to the evolution of intellectual life and power in the people of *la belle France*. He was the poet of the Revolution. Whether he wrote in prose or verse, he was a poet; and no man perhaps ever moved the nation, for whom he lived and thought and wrote, more powerfully. It was not Victor Hugo's fault that his works did not contain more of mind and less of emotion than characterised them. They were the reflex of the mental growth of the period. Had they been of higher calibre, they would have been false to their key-note, out of tune with the spirit of the time. It will be long before France finds as faithful an expositor of the national feeling. Victor Hugo's chamber was the scene of a gallant struggle of life against death. Death vanquished the victor. The man died, but his manly work remains.

DIAGNOSIS OF SMALL-POX.

DR. COLLIER, medical officer of health to the Fulham District Board of Works, in his report for the fourth quarter of 1884, raises a question of some importance to the public. On November 24th he received private information that a girl residing in Westcroft-square had been ill and had had a rash upon her. Visiting the house, he found she was suffering from modified small-pox, and another child was ill with the same disease. The mother had objected to the removal of these patients to hospital, owing to the opinion of the medical attendant that they were suffering from chicken-pox. The first patient had been residing as servant in a house at Richmond, and had returned home with the spots upon her. Her late master had died after a few days' illness. He had been seen by several experienced medical men, and his death had been registered as due to "hæmorrhagic measles." A short time after his death his three children were taken ill; their disease was first thought to be measles, but afterwards chicken-pox. A woman employed to wash the clothes of the father contracted small-pox in a severe form. Nine days after the removal of the cases from Westcroft-square the stepfather of these children was attacked with small-pox. There can be no reasonable doubt that all these persons suffered from small-pox, yet the disease had not been recognised by the medical attendants in the majority of cases. It is very necessary in the public interest that medical men should have an opportunity of making themselves thoroughly acquainted with the different appearances of this disease; medical students in the metropolis are now debarred from doing so owing to the fact that the public institutions receiving these cases are closed to them. We do not desire to dictate to the managers of the Metropolitan Asylums Board in the precautions which they feel it necessary to take to prevent the spread of small-pox from their hospitals, but we believe that it would be quite possible to enable medical men and others to visit these institutions without risk to the public.

HOUSING OF THE WORKING CLASSES IN SCOTLAND.

THE evidence obtained by the Royal Commission on this subject shows that although on the whole the Scotch are better off than the English working classes with regard to dwelling accommodation, there is still the same absence of provision for the very poor. The number of single-roomed tenements, each of which is usually occupied by a family, is very considerable; in Edinburgh there are 14,000 of such tenements, and in Glasgow 5 per cent. of the population live in single rooms. Extensive improvements have been carried out both in Edinburgh and Glasgow with good results. The recommendations of the Commissioners are much the same for Scotland as for England, and among others include that the amount of cubic space demanded for each individual should be increased with a view to discouraging the use of single rooms. There are no special suggestions with reference to the rural population in the Highlands owing to the intention of the Government to legislate on the question of land tenure, but it is recommended that an improved system of local government should be established in the extra-urban parts of Scotland, and that the local authorities should be elected by the ratepayers.

MILK INFECTION.

THE failure of a recent prosecution at Paisley, under the Dairies, Cowsheds, and Milkshops Order, deserves notice, inasmuch as it shows the insufficiency of this Order to protect the public against infectious disease conveyed by milk. We learn from the *Glasgow Medical Journal* that scarlet fever broke out among the drinkers of milk from a dairy at Paisley. A child of the dairyman suffering from scarlet fever had been kept at home, and subsequently two other children of the same family had become infected; the dairyman and his wife at this period milking the cows and serving out the milk. A prosecution was instituted, and it was brought out in evidence that the dairyman and his wife visited the children—a servant stating that her mistress "attended" them; but on behalf of the defendants the children stated that their parents did not "touch" them. The prosecution failed on the point that *contact* was necessary for the purpose of conviction. The order has evidently been drawn by someone who is ignorant of the nature of infection, and its early amendment in this and other respects is urgently needed in the interests of the public health.

THE AMERICAN MEDICAL ASSOCIATION AND THE INTERNATIONAL MEDICAL CONGRESS.

AT its meeting in 1884, the American Medical Association appointed a committee of seven gentlemen to present an invitation to the International Medical Congress at Copenhagen to hold its next meeting in Washington in 1887. As our readers are aware, this invitation was accepted; and the committee, desiring to advance all the arrangements for the meeting, and believing itself to be empowered to do so, proceeded to nominate the chief officers and to conduct the preliminary negotiations. Unfortunately, it seems that in so doing they have excited certain local jealousies; and at the late meeting of the Association in New Orleans their action was discussed and condemned, and a resolution was passed electing a committee, consisting of the seven gentlemen previously appointed and thirty-eight others, "one from each State and territory," who should "proceed at once to review, alter, and amend the action of the present committee as it may deem best." From the reports of the discussion we gather that some members of the Association consider that the appointments in the Congress should be filled up on a geographical basis, each State being considered as a distinct entity to be represented. We trust, however, that the new committee will take a wider and more enlightened view than that, and will make the appointments solely in reference to the merits of the various nominees and the degree to which they possess the confidence of the profession in the United States, as a whole, and in Europe. We may be permitted to assure our American brethren that visitors from Europe will in a large measure judge of the position and character of the profession in the States by the scientific eminence of those whom they choose as their prominent representatives. We trust that all difficulties such as we have hinted at will be wisely and amicably surmounted, and that the meeting of the Congress in Washington will be as signal in its success as a scientific gathering and in its display of true cosmopolitan brotherliness, as any previous one.

MEDICAL MISSION WORK IN CHINA.

FROM the recently issued report for 1884 of the Mission Hospital and Dispensary at Chin-Chew in connexion with the Presbyterian Church in England, it appears that ague, anæmia, dyspepsia, leprosy, and diseases of the eye formed a large proportion of the cases coming for treatment. The whole of the region in which the institution is situated is malarious, but some of the districts markedly so. The quartan variety of intermittent fever was by far the most frequently met with. In the treatment of ague the cinchona febrifuge prepared by the Indian Government has been very largely and successfully used, and only in one or two cases was it known to give rise to irritation of the stomach. The cinchona tree could doubtless be cultivated in many parts of China, and it would be a good thing for the people if the Chinese Government should take steps for its introduction and cultivation in the country. Various circumstances occurred during the year that tended to keep down the number of patients as compared with former years—the principal one being the prevalence of cholera, which broke out in the city in September, 1883, remained in an endemic form during the winter and spring months, and assumed an epidemic form about the beginning of July, 1884. In September the daily death-rate was very high; and the people, becoming much alarmed, left the city in great numbers. In the early part of this month the disease seemed to have taken on a very much more virulent type, and many of the cases were cut off in a few hours after the first symptom of diarrhœa appeared. The Chinese estimated that there were about 3000 deaths from cholera in the city. In October and November the cholera was followed by a form of continued fever, which also in many cases was fatal. This fever had many of the leading features of typhus—the temperature, the eruption, and the constipated condition of the bowels all pointed to typhus. The want of more accommodation for in-patients was very much felt during the year, but, as Dr. Grant observes, in the present unsettled state of the country it would be imprudent to take any active measures towards securing larger premises. The work which is being accomplished by this mission is a great and good one, and in course of time, as the hospital and its advantages become better known, it will be less difficult to get more suitable premises.

COCAINISATION OF THE BLADDER.

DR. P. BRUNS of Tübingen records (*Berl. Klin. Wock.*, No. 21) a case of litholapaxy in which the bladder and urethra had been rendered insensitive by cocaine. The patient had suffered from symptoms of stone for four years, and, on sounding, the stone was found to be hard and rough, and two centimetres and a half in diameter. There was also considerable purulent cystitis. As a preliminary measure the bladder was washed out with boro-salicylate solution; then twenty grammes of a 2 per cent. solution of cocaine were injected into the bladder, and ten grammes into the urethra. By shifting the position of the patient the contact of the injection with all sides of the bladder was ensured. After a few minutes' interval the bladder was filled with the boro-salicylate solution, and the operation proceeded with. Owing to the hardness of the calculus thirty-three crushings were necessary, occupying twenty-two minutes; but during the whole period no pain was felt, although previously the patient had hardly borne the passage of a catheter. During the evacuation pain was experienced each time the bladder was distended, but the anæsthesia had lasted for half an hour. Finally, a small quantity of a 10 per cent. iodoform glycerine solution was injected, with the view of protecting the abraded bladder from purulent absorption. The calculus, which was of the oxalate mulberry variety, weighed four grammes. A speedy recovery ensued.

"THE STRANGE STORY."

IT does not, we confess, strike us as strange that any young woman should out of her disordered or disturbed inner consciousness evolve a story which startles the public. Such stories are certainly not strange in the sense of being rare. They are common-place incidents in the lives of many otherwise estimable females. The most recent specimen of this class is put out of consideration on two sides. First, it is improbable to the extent of being almost impossible that an insensible person could have been publicly moved without the fact being known to somebody who would come forward and bear testimony; and we do not think the narrative is free from contradictions too destructive to be either tolerated or explained.

BARBED WIRES.

SOME time ago our columns contained an annotation, pointing out the dangers likely to arise from the use of barbed wire fencing. What we foretold is fully borne out by the statement in an Inverness contemporary, that much indignation is felt in the Dornoch district at the erection of barbed wire fences close to the public road. Two carriage accidents have recently occurred on a part of the road fenced by this wire. In both cases the horses were seriously cut by the barbs, and one of the animals has since died from the injuries thus sustained. The men in charge were also more or less injured, one of them having the palm of his hand badly torn.

MEDICAL SERVICE IN THE SOUDAN.

WE have read with much satisfaction the account given by the special correspondent of the *Daily Telegraph* of the work done by the medical officers of the late campaign in the Valley of the Nile. He has given an animated and interesting description of the work as he saw it in the advance south of Wady Halfa, and in the severe engagements at Abu Klea and Abu Kru. He bears testimony to the completeness of the provision made by the head of the department for the care of the sick and wounded, and to the ability with which the arrangements were carried out by the officers in charge of the service in the Soudan. He has done a good service to the medical staff by giving a graphic account of the difficulties they experienced and the dangers to which they were exposed in the discharge of their arduous and important duties; of the cool, quiet, and methodical manner in which these were performed, and of the courage displayed in affording aid to the wounded upon the field regardless of risk and danger. "Trying as oftentimes is the situation of a medical man in civilised warfare, it is as nothing compared with the risk, responsibility, and labour devolving upon him when the contest is waged against a ferocious and savage enemy. In such a position he renders services that can scarcely be overrated." The details given of the work done by the medical officers are interesting as "a tale of forethought, diligence, capacity, and courage." The description of the services thus rendered by the medical staff affords important evidence of the value of the present organisation of the department. The correspondent states that "in equipment and supplies no department of the army was more fully provided, and ahead in all details, or better prepared to cope with work than the Medical Department"; the results were so satisfactory that he heard expressions of dissatisfaction only on two occasions, and in both instances from men who got "neither credence nor consolation for certain alleged ailments they had sought to get treated for." We trust that, although from a military and political point of view the campaign has been a failure, the labours of Surgeon-General O'Nial and the medical staff will not be overlooked, but that they may receive some appropriate recognition of the able, energetic, and satisfactory manner in which they have discharged their onerous professional duties.

PUERPERAL FEVER IN BOMBAY.

IT is no exaggeration to say that during 1884 puerperal fever was a household topic among the Parsees in Bombay. The causes of the epidemic are very fully examined and discussed in a paper on the subject read by Dr. Temulji before the Grant College Medical Society. The fever seems to be more prevalent in the hot months of the year, especially before the rain sets in. This may be accounted for by the unsatisfactory state of the drains of the several parts of the city, their stagnation at different points, and the foul emanations therefrom due to extreme solar heat. Puerperal fever is not so prevalent amongst the other sections of the native community as among the Parsees, and the reasons for this are obvious. The Parsees, from false prejudices, get their women delivered on the ground floor, in many cases in a room set apart for the purpose, which as a rule is the worst part of the house, with drains either underneath or passing by the side, and the sewer air freely escaping into every part of the room; and this perhaps is concentrated on account of the doors and windows being closed for fear of the patient catching cold. Another fertile cause of this fever is the bedding which the Parsee ladies use during accouchement. After the forty days are over, they give away all their clothing and bedding to the Bhangees or Halalcores, who, looking upon them as a source of profit, sell the same without the least thought of disinfecting them. From the cotton of the beddings thus given away new ones are made and sold, which are bought by many of the Parsee ladies either for themselves or for their female attendants for use during confinement. The last, though not the least, important cause is, probably, the low vital stamina of the Parsee girl of the present period, the result probably of evils usually accompanying a higher civilisation. Want of exercise is, no doubt, a prime factor in the physical deterioration of the Parsee girls of this generation; they are disposed to lead a more easy life than their mothers and grandmothers did, and consequently they are incapacitated for severe bodily exertion.

THE UNIVERSITY OF LONDON.

WE understand that the Special Committee appointed by the Sub-Committee of Convocation have agreed on a draft report, recommending the gradual abolition of life-senatorships, the direct representation of the colleges and large teaching bodies, and the formation of Boards of Studies for the regulation of examinations. The reforms which we have so often urged will therefore be soon brought authoritatively before the University, and they, to a very great extent, coincide with the bases suggested by the promoters of the Teaching University movement.

THE EXAMINATION IN ELEMENTARY ANATOMY AND PHYSIOLOGY.

ONE of the most interesting features of the English conjoint examination scheme is the examination at the end of the first year in elementary anatomy and physiology. We understand the number of candidates was 363. Of these, 340 passed in anatomy and 23 were rejected. In physiology 320 passed and 43 were rejected. We expect great good from students being required at the end of the first year to give a slight account of their stewardship.

THE LAW AS TO DUSTBINS.

THE owner of a dustbin calls attention in a daily newspaper this week to the unfortunate position in which the householder is placed in having no immediate remedy when the parish officials neglect to remove his house dust and refuse. In point of law his dust does not belong to himself but is the property of the contractor, who alone has the right to remove it. If he were, with his neighbours, to make application to the magistrate for a summons against the contractor as the person by whose act or default a nuisance is committed, it would be easy to plead in defence that the dustbin should receive only dry material ashes, &c., and that the nuisance is really created by the householder himself in putting into the dustbin vegetable and animal matter, which ought to have been burnt upon the kitchen fire. After all has been said there is a remedy in the hands of the owner of the dustbin, and one far more effectual than that of complaining to a magistrate or the public. If he will exercise his powers as a ratepayer to see that proper persons are returned as vestrymen he would soon have no further ground for dissatisfaction.

THE NUDE.

THE protest of "A British Matron" may have been wild and uncalled for. All the same, it is, beyond question and wholly apart from a fastidious taste, perfectly true that no inconsiderable proportion of the Art of the day appeals—intentionally—to a passion which, however cultured it may be, is not exclusively intellectual in its conception of the beautiful. It is idle to pretend that a purely Platonic love of the exquisite and refined, in colour and form, attracts the gaze

of thousands to the increasing multitude of pictures representing the female form unclothed. The truth is, we in England are too much influenced by the French type of artistic taste and enterprise. Lady Godivas and Surprised Bathers have been becoming increasingly numerous of late. By all means let those who like such pictures employ artists to paint them. This is a free country. It is not, however, necessary, nor, we think, desirable, to crowd the walls of our few public picture galleries with this parade of the beautiful. When, in the cycle of fashionable progress, the time comes for our women to appear in ordinary life as they are portrayed on these equivocal canvases, the latter will cease to be outrageous because they will have become commonplace.

THE PORT SANITARY AUTHORITY AND INFECTIOUS DISEASES.

REGULATIONS made by the Port Sanitary Authority for the Port of London, and approved by the Local Government Board, for the removal to hospital of persons, brought within the port by any ship, who are infected with a dangerous infectious disorder, have just been issued. By their provisions the master of every vessel is bound to report any case of infectious disease to the medical officer at Gravesend, and to remove the patient to hospital there under his supervision. The expression "dangerous infectious disorder" is explained to mean any of the following diseases: cholera, diphtheria, erysipelas, measles, scarlatina, small-pox, typhoid or enteric fever, typhus fever. A penalty is incurred for non-compliance with these regulations.

EPIDEMIC CEREBRO-SPINAL MENINGITIS.

THERE seems every probability of an outbreak of epidemic cerebro-spinal meningitis in Berlin; for within the last few weeks Professor Senator has had under his care at the Charité Hospital three cases in quick succession, and he has seen four other cases in consultation.

FROM the report of the examination made by Colonel Sir Francis Bolton of the water supplied by the several metropolitan water companies during the month of April, it appears that the Thames water distributed by the Chelsea, West Middlesex, Southwark, Grand Junction, and Lambeth Companies, contained in every case less organic matter than in the previous month's samples, the improvement being most marked in the case of the West Middlesex and Chelsea Companies' waters. The water drawn from the Lea and delivered by the New River and East London Companies also exhibited a considerable improvement as regards organic matter, the amount of the latter being less than in any of the Thames waters. All the waters were clear and bright on delivery.

AT a meeting of the Council of the Queen's College, Birmingham, held on the 21st inst., Dr. James Sawyer, F.R.C.P., Senior Physician to the Queen's Hospital, was unanimously elected Co-Professor of Medicine as the colleague of Dr. Foster. Dr. Rickards, Physician to the General Hospital, and Dr. Carter, Physician to the Queen's Hospital, were elected Co-Professors of Materia Medica and Therapeutics in succession to Dr. Sawyer.

THE *Crofter* this week gives a portrait and short sketch of the professional and political career of Roderick Macdonald, M.D., F.R.C.S.E., whose name has become familiar to newspaper readers as a Parliamentary candidate for Ross-shire, and as leader in the movement to secure for the crofters representation in Parliament as the only satisfactory means of redressing their wrongs and grievances.

TYPHUS fever is reported to have assumed a serious form at Massowah. Some cases appeared at the end of April, but there were no deaths until the 24th of that month. Since then the temperature has risen rapidly, the heat becoming terrible, and the epidemic has made many fresh victims. In four days the Italian expeditionary force lost four officers, and the deaths of ten soldiers occurred in three days.

IT is understood that Professor Huxley will shortly resign his Inspectorship of Salmon Fisheries. Among those spoken of as his probable successor are Mr. Francis Day, Mr. Cholmondeley Pennell, and Professor Ray Lankester. We have no reason for apprehending that, if his resignation be tendered, it is owing to any serious impairment of his health.

DR. E. VAN EBMENGEN, who was commissioned by the Belgian Government to proceed to Marseilles in order to inquire into the epidemic of cholera there last year, has published an elaborate report containing the results of his investigation. We shall deal with this important document fully next week.

ON the 26th inst. the death occurred at Manchester of Dr. John Thorburn, Professor of Obstetric Medicine at Owens College, at the age of fifty-one. Dr. Thorburn also held the post of Obstetric Physician to the Manchester Royal Infirmary.

THE SANITARY CONFERENCE AT ROME.

AFTER oft-repeated delays the International Sanitary Conference of 1885 has at last been opened at Rome. On the 20th inst. the delegates were introduced by their several ambassadors to Signor Mancini, Minister for Foreign Affairs, and the inaugural address was then delivered by the Minister, who spoke as follows:—

"Gentlemen, I am proud that the choice of offering you a hearty welcome has fallen upon me. His Majesty the King, my august Sovereign, has charged me to convey to you the great satisfaction he feels at the friendly and sympathetic reception with which Italy's proposal for the assembling of this Conference has been received in all parts of the world. His Majesty is rejoiced to see in his capital representatives of all Governments, assembled in order to fulfil the mission of studying and resolving one of the most important problems with which modern civilisation is at present occupied—namely, the preservation of human life. We took the initiative in this matter immediately after the reappearance on the banks of the Nile, in 1883, of that terrible plague which had already so many times ravaged Europe. Your presence here is the best augury for the success of the work you have undertaken. For the first time since sanitary questions commenced to form the subject of international debates, the assembly which will now take up the study once more sees in the midst of the eminent men of which it is composed both men who are learned and specially fitted for their task by reason of their scientific competence and their long experience, and also those who, being accredited to the Government of his Majesty the King, have a claim to speak on behalf of their several countries. It is for you, gentlemen, to arrange the order of your proceedings; but whatever may be your decision in this matter, I think that the Conference, whilst discarding as much as possible mere theoretical discussions, and thus giving to its labours an essentially practical character, may well hold a double object in view. I feel that it is above all things important to establish between the several Governments some agreement which shall form the basis on which they may, in their respective countries, establish such measures of prevention, surveillance, and isolation as are necessary in order to deal with this plague at its source, and, as far as possible, to prevent its development. But since, notwithstanding such precautions as it may be possible to take, the disease may threaten to diffuse

itself, it will be necessary, in view of such a contingency, to endeavour also to come to some understanding as to the adoption in the several countries of some system of defence against the invasion and diffusion of the disease, which, without laying burdens which are excessive and rarely efficacious on the freedom of communication and commerce, shall be rational and at the same time of practical utility. Gentlemen, your duty will be no less difficult than it is important. But if your efforts, as I venture to hope, are not barren of results, and if the conclusions to which you come, being accepted by your respective Governments, should be embodied in an international convention, you will have the right to congratulate yourselves, and will have deserved the gratitude of the whole human family. Far beyond the mere prestige of power and the splendour of victories, it is those services which are rendered to humanity and to civilisation that take the highest rank in the annals of the world. They stand as the purest and most legitimate of all the titles of nobility which occupy a place in the history of peoples. I trust and hope that of such may be the results of this Conference, which I now have the honour to inaugurate, and which I now declare to be open."

The actual labours of the Conference commenced at once by the election of Signor Cadorna, President of the Council, as President of the Conference. Certain preliminaries as to the proceedings and debates were also provisionally agreed upon, and the Conference adjourned until Friday, the 22nd inst., when it was hoped that all the foreign delegates would have arrived. With a view of facilitating the labours of the Conference, the medical delegates were, on the second day of meeting, formed into a technical commission, which will discuss the various decisions arrived at by the Vienna Conference of 1874, and which will then submit the conclusions they arrive at to the Conference as a whole.

As far as can be judged from Signor Mancini's inaugural address, and from the *personnel* of the Conference, it is evident that there will be a determined effort on the part of many to maintain quarantine by sea, although perhaps under somewhat less onerous conditions than heretofore. England, as is well known, will never again impose this antiquated restriction against cholera, and it is to be hoped that the British delegates may succeed in showing their *confrères* that our present system of medical inspection and isolation, coupled with a progressive improvement in the general sanitary circumstances of the kingdom, is the only system which is at the same time rational and capable of efficient execution. We must, however, not be too hopeful in this matter; the realisation of which will be the more improbable if we again find ourselves this summer face to face with an extending cholera epidemic. Panic will then doubtless once more reign supreme.

So far, however, the Technical Commission has done good work, having inaugurated its sittings by a vote which, with the exception of Turkey alone, recorded with unanimity a condemnation of quarantine measures by land. The lesson of 1884 has not therefore been altogether without its results, and is is to be hoped that this decision will be ratified by the Conference as a whole, and that it will lead to the adoption of those measures of sanitary improvement which afford the greatest obstacle against the spread of cholera.

The following are the names of the diplomatic and scientific delegates to the Conference who are now in Rome. One or two minor States whose delegates have not arrived may be represented later on:—

Argentine Republic: M. del Viso (Minister Plenipotentiary). *Austro-Hungary:* Count Ludolf (Austrian Ambassador), Dr. de Hofmann, Dr. Grosz, Count Batthyanyi. *Belgium:* M. Van Loo (Minister Plenipotentiary). *Brazil:* M. Callado (Minister Plenipotentiary), Dr. d'Azambuja. *Chili:* M. Matta (Minister Plenipotentiary). *China:* General Tcheng-Ki-tong. *Denmark:* M. de Hegermann Lindencrone (Minister Plenipotentiary). *France:* M. Decrais (French Ambassador), Dr. Proust. *Germany:* M. de Keudell (German Ambassador), Dr. Koch, Dr. Erhardt. *Great Britain:* Sir J. Savile Lumley (British Ambassador), Sir Guyer Hunter, Dr. Thorne Thorne. *Greece:* M. Rhasis (Minister Plenipotentiary). *Guatemala:* M. Segarini (Consul-General). *India (British):* Sir Joseph Fayrer, Dr. T. Lewis. *Italy:* M. Cadorna, President of the Council of State (President of the Conference), Dr. Baccelli, Dr. Moleschott (President of the Technical Commission of the Conference), Dr. Semmola, Dr. Buonomo, Naval Commander Randaccio, M. Casanova, M. Scibona. *Japan:* M. Tanaka (Minister Plenipotentiary), M. Nagay. *Mexico:* M. Sanchez Azcona (Resident Minister), Dr. Hijar y Haro. *Netherlands:* M. de Westenberg (Minister Plenipotentiary), Dr. Ruysch. *Peru:* M. Brunialti. *Portugal:* M. de Carvalho e Vasconcellos (Minister Plenipotentiary), Dr. Da Silva Amado. *Roumania:* M. Obédénnare (Minister Plenipotentiary). *Russia:* Baron d'Uxkull Gyllenband (Russian Ambassador), Dr. Eck. *Servia:* M. Franassovich, Dr. Danitch. *Sweden and Norway:* M. Linstrand (Minister Plenipotentiary), Professor Bergman, Dr. Dahl. *Switzerland:* M. Bairer (Minister Plenipotentiary), Dr. Reali, Dr. Sonderegger. *Turkey:* Mihrau Effendi (Charge d'Affaires), Dr. Zoéros Pacha. *Uruguay:* M. Antonini y Diez (Minister Plenipotentiary).

THE MEDICAL AND CHIRURGICAL SOCIETY OF JAPAN.

AMONGST the many recent advances made by the Japanese in the adoption of European institutions that which relates to medical science is not the least significant. Two years ago we had the pleasure to notice a promising medical journal, the *I Ji Shimbun*, which still receives the support of those for whom it was intended; and we have now to record the success of an Association, the Sei I Kwai, established on the basis of the London Royal Medical and Chirurgical Society, for the advancement of medical science in Japan.

The Sei I Kwai, which issued its thirty-sixth monthly Fasciculus of Transactions in January last, numbers eighty-six members, including nearly all the leading representatives of the profession in Tokio, and some of the principal foreign practitioners, and is under the presidency of Mr. K. Takaki, F.R.C.S., the Director-General of the Naval Medical Department, formerly a distinguished pupil of St. Thomas's Hospital. Its business is conducted at weekly ordinary meetings, when cases are brought forward and discussed in due form, papers are read, and points of interest in foreign journals are quoted and commented upon; and at special monthly meetings held for the more systematic discussion of subjects previously announced.

The January and February numbers of the Transactions now before us present a courageous innovation, the addition of a supplement in which certain of the contents appear in English form and so become available for use and criticism by the outside world. In the January part the supplement is introduced by a report of Four Cases of Ovariotomy performed under complete Antiseptic Precautions by Mr. Takaki, with the result of three successes against one death, the fatal termination being due to shock and hæmorrhage induced by the removal of an extensively adherent tumour of very large dimensions.

Mr. Furukawa Sakayé follows with an interesting paper on Japanese Cosmetics. We learn from this that the use of the toilet adjunct in question, which is confined to women and actors, commenced as early as 724 A.D. The main ingredient, according to the analysis of Professor Atkinson (Trans. As. Society of Japan, vol. vii.), is carbonate of lead diluted with powdered rice starch. No charge of poisoning has ever been raised against the composition; but, on the other hand, it is supposed to exert a wonderful curative influence upon certain skin diseases, which Mr. Furukawa Sakayé unfortunately omits to name.

A report by the Central Sanitary Bureau of cases of Poisoning collected from the various provinces during the half-year ending June, 1884, is next quoted, and it appears that of a total of 132 instances recorded seventy resulted from eating poisonous fish, forty, with twenty-three deaths, being set to the score of the tetradon. The subject of tetradon poisoning is discussed in a subsequent paper.

A statistical table to show the prevalence of Myopia amongst the students of the Agricultural College at Sapporoni Yezo is contributed by Dr. J. C. Cutler, and states that of the pupils (whose total number is not mentioned) entering the College 29·5 per cent. were already myopic, and that an additional percentage of 23 developed the complaint after admission. As a reading people the Japanese have always suffered from myopia, but there is reason to hope that in the future its frequency may be diminished by improvements in printing, and an increased knowledge of the

bearing of properly constructed desks &c. in schools upon the question of visual defects.

In the February number Dr. Osawa writes an account (translated by Mr. Tsuruda) of Tetradon Poisoning, the frequency and fatality of which have already been referred to. From this it appears that three-fourths of the twenty known varieties of the fish are found to be more or less poisonous; that the intensity of the virus increases in certain seasons, notably during the period of gestation in the month of April; that the poisonous principle is located in the ova, and sometimes in the liver also, the flesh being innocuous; and that it is active during the life of the fish, and does not develop as in the bonito and other members of the tribe as a result of post-mortem changes. The poison is described as a crystalloid, readily diffusible from the tissues into water, slightly soluble in ether, chloroform, and spirit, and susceptible of preservation for a considerable period (two months in the case of the eggs of the T. chrysops). It is said to kill by asphyxia. The writer concludes an able paper with the pithy assurance that "the only prophylactic against poisoning by the fish is to avoid eating it."

A report of the Diseases and Injuries of the Mariners in the Japanese Navy during the year 1883 presents the noteworthy feature that out of a total of 2335 cases registered under the head of general diseases, no less than 1292, with a mortality of 3·75 per cent., were due to "kakké," a disease probably of malarious origin, which appears to be identical with the beriberi of India.

The number closes with a translation of an imperial decree relating to the Licensing of Medical Practitioners in Japan. These regulations having necessarily been constructed with reference to the present stage of transition in medical education, must undergo considerable modification as time and knowledge progress; but they are well adapted for existing circumstances, and framed in a spirit of indulgence that should leave no grounds for complaint from candidates who desire to assume the grave responsibilities of the physician.

THE HEALTH OF IRELAND IN 1884.

THE General Abstract recently issued by the Registrar-General of Ireland affords valuable statistical evidence of the health condition of that portion of the United Kingdom during last year. It appears that, though the excess of births over deaths was 31,631, the population decreased 44,232 during the year, owing to the emigration of 75,863 persons. The population of the country has declined year by year since 1877, when there was a slight reaction from previous decline, and was estimated to be 4,962,570 in the middle of last year. The marriage-rate showed an increase last year, and was higher than in any year since 1878, indicating a tendency to revival of prosperity. The birth-rate, too, was slightly higher than in 1883, and equal to 24·0 per 1000, but was 1·2 below the mean rate in the preceding ten years. The death-rate was 17·6 per 1000, against 17·4 and 19·2 in the preceding two years, and was 0·8 below the mean rate in the ten years 1874-83. The marriage-, birth-, and death-rates in Ireland are all very considerably below those prevailing either in England or Scotland, with which, however, they are not comparable, owing to the abnormal age proportions of the Irish population. The constantly large amount of emigration from Ireland during a long series of years has depleted the population of that country of so large a proportion of its young adults that the marriage- and birth-rates are necessarily reduced. The unduly small proportion of children and young adults necessarily affects the gross death-rate, and destroys its value for comparative purposes, unless due correction be made for exceptional age distribution of the population; but such correction is not made by the Registrar-General for Ireland. The Irish General Abstract now under notice gives, however, much more information than the corresponding General Abstract for England and Wales, which gives only bare facts, without any calculated rates. The deaths referred to the principal zymotic diseases in Ireland last year were equal to 8·2 per cent. of the total deaths, and to a rate of only 1·46 per 1000 of the estimated population, which was 0·49 below the mean annual rate from the same diseases in the preceding ten years. Only one death was referred to small-pox during the year. The zymotic death-rate in Ireland last year was little more than half the rate from the same diseases in England and Wales, but this may to some extent be attributed to the small proportion of children in the Irish population, as children under ten years of age are invariably the greatest sufferers from zymotic diseases. One of the most useful features in this Irish return is one which we should much like also to see in the English return; this is the death-rate in each of the urban sanitary districts. The defect in this table is that the rates in 1884 are calculated upon the enumerated population in 1881; the rates, therefore, for the whole of Ireland in this table differ considerably from those given in other tables. All the rates in this table are more or less understated in consequence of the decline that has taken place in the Irish population since 1881. However, the rates respectively given for the urban and rural sanitary districts are interesting, although they require correction for difference of age distribution, as well as for the want of duly estimated populations. The urban birth-rate is given as 29·4, while in the rural districts it did not exceed 21·4. The death-rate was 24·7 in the urban and only 14·9 in the rural districts; and the zymotic rate, which was 2·8 in the urban districts, did not exceed 1·0 in the remaining or rural districts. Excluding the smallest towns, the highest death-rates in the Irish urban sanitary districts during last year were 26·3 in Limerick, 26·7 in Cork, and 29·8 in Waterford. It is doubtful, however, how these rates would have been affected if they had been calculated upon the estimated population in the middle of 1884, instead of upon the enumerated population in 1881. The statistics of infant mortality in Ireland are exceptionally favourable. The deaths under one year of age last year did not exceed 92·5 per 1000 of the registered births in Ireland, whereas the proportion in England was equal to 147 per 1000. Whether viewed as a test of sanitary condition or of care of infant life, this low rate of infant mortality in Ireland is eminently satisfactory.

WILLS OF MEDICAL MEN.

THE will and two codicils of Mr. John Mann, formerly of 4, Charterhouse-square, surgeon, but late of Warltersville-road, Hornsey-rise, and of Moreton-in-the-Marsh, Gloucestershire, who died on January 11th last, were proved on the 1st ult. by Mrs. Mary Mann, the widow, and Mr. George Loosely, the acting executors, the value of the personal estate amounting to over £18,000. There are gifts to his wife, to each of his four children, and to his executor, Mr. Loosely; and as to the residue of his property, the testator leaves two-fifths to his daughter, Elizabeth Frances, and one-fifth each to his children, Joseph Procter, Mary Rebecca, and Edith Spear.

The will and two codicils of William Bruce Joy, M.D., F.C.P. in Ireland, late of 16, Pembridge-gardens, Bayswater, who died on January 28th last, have been proved by Mr. Albert Bruce Joy and Mr. George William Joy, the sons, the executors, the value of the personal estate exceeding £2400. The testator leaves to his wife, Mrs. Arminella Joy, all his furniture and effects, cash in the house and at his bankers, and an annuity of £500; to his son, Archibald Edward, an annuity of £250; and to Frederick James McDonnell, £100. Subject to the foregoing, he leaves his estate of "Joy's reclaimed Dam," Belfast, and his other estates in Ireland with the residue of his real and personal property as to two-thirds for his son, Albert Bruce, and as to one-third for his son, George William.

The Irish probate granted at Dublin of the will of Samuel Warren, M.D., late of Hoylake, Cheshire, and of 83, Grosvenor-square, Rathmines, Dublin, who died on Feb. 12th last, to Mrs. Frances Elizabeth Warren, the widow and sole executrix, has been resealed in London, the value of the personal estate in England and Ireland exceeding £1500. The testator gives, devises, and bequeaths all the real and personal estate which he shall die seized or possessed of to his wife absolutely.

The following legacies have recently been left to Hospitals and other medical charities:—Mr. Francis Parsons, of Ashford House, Hornsey, £500 each to St. Albans Dispensary and the Hemel Hempstead Infirmary.—Mr. Stephen Cooke, of Bucking-

ham, £300 to the Cancer Hospital, Brompton; £200 to the Horton Infirmary, Banbury; and £100 each to St. Bartholomew's Hospital, Guy's Hospital, the Hospital for Women and Children, Vincent-square, Westminster, the new Hospital for Women, Marylebone-road, the Hospital for Consumption and Diseases of the Chest, Brompton, the Royal Hospital for Diseases of the Chest, City-road, the National Hospital for Paralysis and Epilepsy, Queen-square, Bloomsbury, the Royal London Ophthalmic Hospital, Blomfield-street, Moorfields, St. Peter's Hospital, Henrietta-street, and the Buckingham Nursing Hospital.—Mr. Robert Barbour, formerly of Manchester but late of Bolesworth Castle, Cheshire, £500 to the Chester General Infirmary.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF INSPECTORS OF THE MEDICAL DEPARTMENT OF THE LOCAL GOVERNMENT BOARD.

Registration District of Bedwelty.—Mr. John Spear has recently re-inspected the urban sanitary districts of Ebbw Vale and Abertillery, and the rural sanitary district of Bedwelty, comprising the above area. He reports, with regard to the Ebbw Vale district, that a sewer has been laid at Cwm and another is in course of construction at Wainellwyd. At Chapeltown a plan for sewerage has been approved by the authority, and for Briery Hill plans are in course of preparation. It is proposed to defray the cost of these works out of the current rates, and the work will therefore be proceeded with very slowly. It is also intended that the sewage, unpurified, should be discharged into the Ebbw, a course to be deprecated. There has been considerable improvement since Mr. Spear's previous visit in 1882 in the matter of both privy accommodation and scavenging. New houses are now supplied with a closet of the Manchester pattern, and the pails are regularly emptied; but there are still some 2300 houses either without privy accommodation or with a provision of the worst kind. There is, however, no change in the water-supply, but there is some improvement in house construction. Mr. Spear points out methods by which older cottage property might be improved both as regards ventilation and prevention of dampness. Reporting on the Abertillery district, he refers to the prevalence of typhoid fever in 1882, 1883, and 1884, the result of excremental pollution of earth, air, and water. Little, however, had been done but the provision of a small amount of sewerage, and no proper efforts are made to improve the condition of houses.

In the Bedwelty rural district, Mr. Spear states that the sanitary condition of the villages is deplorable; in a few places attempts have been made to provide sewers, and there is a prospect of an improved water-supply, but the building bye-laws are not enforced, and no attempt is made to isolate infectious disease.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Hanley Urban District.—On an estimated population exceeding 51,000, the birth-rate was 38·8 and the death-rate 21 per 1000, both rates exhibiting a decrease on the mean of preceding years. The infant mortality also last year showed a decline from the higher rates that obtained in 1882 and 1883, but it was still markedly in excess of the rates prevailing amongst other corresponding urban populations. The rate of death from the seven principal zymotic diseases was also high—namely, 3·6 per 1000, and 73 deaths were registered from diarrhœa and dysentery. Unfortunately the report, professedly relating to the "sanitary condition" of the borough, is little else than a record of statistics, and hence we are unable to judge of the conditions leading to preventable death, or of the advice which has been given in order to improve the state of the district. The action taken by the inspector of nuisances, as tabulated in an appendix, points to efficiency on the part of this officer.

Jarrow (Urban).—The medical officer of this borough in his report for 1884 expresses his belief that the lamentable depression of trade, and consequent distress among the working classes, had an appreciable effect upon the mortality statistics of the year. The population of the borough is estimated at 29,000, showing a higher rate of increase than prevailed between 1871 and 1881; that the population, however is not over-estimated appears probable from the fact that the birth-rate calculated upon the medical officer's estimate was equal to 43·9 per 1000. This rapid increase of population at a time of such heavy depression is a noteworthy fact. The death-rate, after the due addition of the deaths belonging to the borough recorded in the Union Workhouse outside the municipal boundaries, was equal to 23·5 per 1000; and, in spite of a considerable reduction in the mortality from zymotic diseases, showed a slight increase upon the rate in the previous year, and exceeded by 2·2 per 1000 the mean rate in the ten years 1873-82. Dr. Munro considers that there is a close relation between this increase in the death-rate and the existing "bad times," a conclusion supported by the fact that zymotic fatality, other than that due to infantile diarrhœa, had declined. Infant mortality, measured by the proportion of deaths under one year to births, was equal to 163 per 1000, and exceeded that which prevailed in any year since 1878, when the summer was hot and the fatality from infantile diarrhœa excessive, as was the case last year. The deaths from the principal zymotic diseases were equal to 3·8 per 1000 of the estimated population, and showed a considerable decline from the rates in the preceding two years, which were 5·0 and 5·1. It is noted that the annual zymotic death-rate in the borough during the five years 1874-78, before the introduction of the system of compulsory notification of infectious diseases, was 5·7 per 1000, whereas it has declined to 3·8 in the six years since notification was introduced. This is important evidence in favour of notification, although it would not be safe to attribute the decline entirely to this cause. In connexion with this subject it is to be regretted that very little progress appears to have been made during the past year in the provision of permanent hospital accommodation for infectious diseases.

Bedford Urban District.—Dr. Prior reports that Bedford continues to exhibit a very low death-rate, it having been 15 per 1000 last year; the zymotic rate was also only 1·5 per 1000. Diphtheria, which some years since prevailed so very widely, is still troublesome, but it is mainly confined to a comparatively small portion of the town lying south of the river. The various conditions, such as dampness, states of sewers and drains, &c., which might account for this localisation of the affection, have been carefully considered, and Dr. Prior is inclined to think that, after all, the circumstance is really due to the propagation of the disease by means of a series of mild and unrecognised cases in this special locality.

Willesden Urban District.—This district has now a population of over 36,000, and last year it achieved, notwithstanding its rapid increase of inhabitants, the end of attaining the smallest death-rate on record—namely, 14·6 per 1000. There was some increase in the amount of zymotic disease, but this was mainly due to a prevalence of whooping-cough, a disease against the spread of which no practical measures of prevention can as yet be regarded as available. Owing to a prevalence of small-pox, and to the failure of the authority to prepare themselves with proper means of isolation, hospital tents were procured, and subject to infectious disease not making its appearance at an unsuitable time of the year, the tents may be regarded as still available. An ambulance is very much needed, there being no proper means for the removal of patients. Dr. Branthwaite also suggests a chair for carrying the sick downstairs, but nowadays every proper ambulance is fitted with a movable stretcher which the patient is laid on in his bedroom, which is then made to slide into the ambulance, and on which he is carried from the ambulance to the hospital bed. If the recumbent position be unnecessary, the stretchers can always be so adapted as to suit other positions.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In twenty-eight of the largest English towns 5443 births and 3594 deaths were registered during the week ending the 23rd inst. The annual death-rate in these towns, which had been equal to 20·2 and 20·4 per 1000 in the preceding two weeks, further rose last week to 21·1. During the first seven

weeks of the current quarter the death-rate in these towns averaged 22·1 per 1000, against 23·0 in the corresponding periods of the nine years 1876–84. The lowest rates in these towns last week were 13·3 in Bolton, 17·3 in Bradford, 17·5 in Halifax, and 18·0 in Leicester. The rates in the other towns ranged upwards to 29·1 in Manchester, 30·0 in Newcastle-upon-Tyne, 30·1 in Preston, and 31·5 in Blackburn. The deaths referred to the principal zymotic diseases in the twenty-eight towns, which had been 481 and 463 in the previous two weeks, rose to 510 last week, and included 182 from measles, 158 from whooping-cough, 42 from diarrhœa, 40 from scarlet fever, 37 from "fever" (principally enteric), 34 from small-pox, and 17 from diphtheria. No death from any of these principal zymotic diseases was returned last week in Derby, whereas they caused the highest death-rates in Birkenhead, Blackburn, and Newcastle-upon-Tyne. The greatest mortality from measles occurred in Liverpool, Birkenhead, and Newcastle-upon-Tyne; from whooping-cough in Oldham, Plymouth, and Blackburn; from scarlet fever in Wolverhampton; and from "fever" in Cardiff and Norwich. The 17 deaths from diphtheria in the twenty-eight towns included 10 in London and 2 in Preston. Small-pox caused 66 deaths in London and its outer ring of suburban districts, exclusive of 22 deaths of London residents recorded in the hospital ships and camp at Darenth; also 2 in Manchester, 2 in Sheffield, 1 in Hull, and 1 in Sunderland. The number of small-pox patients in the metropolitan asylum hospitals situated in and around London, which had been 1282, 1361, and 1364 on the preceding three Saturdays, further rose to 1374 at the end of last week; the admissions, which had been 315 and 211 in the previous two weeks, rose again to 282 last week. The Highgate Small-pox Hospital contained 68 patients on Saturday last, 15 cases having been admitted during the week. The deaths referred to diseases of the respiratory organs in London, which had been 287 and 291 in the preceding two weeks, further rose last week to 304, and were 5 below the corrected average. The causes of 62, or 1·7 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Brighton, Bradford, Preston, and in four smaller towns. The largest proportions of uncertified deaths were registered in Sheffield, Halifax, and Bristol.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been equal to 20·6 and 23·4 per 1000 in the preceding two weeks, declined again to 21·2 in the week ending the 23rd inst., and was almost identical with the mean rate during the same week in the twenty-eight large English towns. The rates in the Scotch towns last week ranged from 10·6 in Leith and 18·0 in Edinburgh, to 22·0 in Paisley and 24·7 in Glasgow. The 517 deaths in the eight towns showed a decline of 53 from the number in the previous week, and included 22 which were referred to whooping-cough, 16 to diarrhœa, 15 to measles, 8 to "fever" (typhus, enteric, or simple), 3 to scarlet fever, 3 to diphtheria, and not one to small-pox; in all, 67 deaths resulted from these principal zymotic diseases, against 55 and 79 in the preceding two weeks. These 67 deaths were equal to an annual rate of 2·7 per 1000, which was 0·3 below the mean rate from the same diseases in the twenty-eight English towns. The 22 deaths from whooping-cough in the eight towns showed a further decline from the numbers in recent weeks, and included 12 in Glasgow, 4 in Dundee, and 3 in Edinburgh. The 16 deaths attributed to diarrhœa were fewer by 3 than those in the previous week, but exceeded the number in the corresponding week of last year by 5. The fatal cases of measles, which had been 13 and 19 in the previous two weeks, declined again to 15 last week, all of which occurred in Glasgow. The 8 deaths referred to "fever" corresponded with the number in the previous week, and included 5 in Glasgow and 3 in Edinburgh. Two of the 3 deaths from scarlet fever, and 2 of the 3 from diphtheria, were returned in Glasgow. The deaths referred to acute diseases of the respiratory organs in the eight towns, which had been 117 and 95 in the preceding two weeks, rose again to 107 last week, and were 7 above the number returned in the corresponding week of last year. The causes of 76, or nearly 15 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 28·5 and 35·0 per 1000 in the preceding two weeks, declined again to 31·2 in the week ending the 23rd inst. During the first seven weeks of the current quarter the death-rate in the city averaged no less than 32·6 per 1000, the mean rate during the same period not exceeding 20·8 in London and 18·4 in Edinburgh. The 211 deaths in Dublin last week showed a decline of 26 from the number in the previous week, and included 17 which resulted from measles, 6 from "fever," 6 from scarlet fever, 2 from whooping-cough, 1 from diphtheria, 1 from diarrhœa, and not one from small-pox. Thus, 33 deaths resulted from these principal zymotic diseases, against 22 and 34 in the preceding two weeks; these 33 deaths were equal to an annual rate of 4·9 per 1000, the rate from the same diseases last week being 3·1 in London and 1·7 in Edinburgh. The fatal cases of measles in Dublin, which had been 17, 12, and 14 in the preceding three weeks, rose again to 17 last week. The 6 deaths from scarlet fever, and the 6 from "fever" (typhus, enteric, or simple), also exceeded the numbers in recent weeks. The deaths from diarrhœa and whooping-cough, on the other hand, showed a decline. Three inquest cases and 2 deaths from violence were registered within the city; and 63, or nearly a third of the deaths, were recorded in public institutions. The causes of 22, or more than 10 per cent., of the deaths registered during the week were not certified.

THE SERVICES.

Amongst the officers who left Sawakin on the 22nd inst. in the *Calabria* was Surgeon P. A. Hayes, and amongst those who left in the *Ganges* on the 27th inst. was Surgeon N. Manders.

The following medical officers have arrived at Cairo, sick, from the Nile:—Surgeon-Major R. W. O'Donnell, and Surgeons R. H. Clements, W. S. Pratt, F. H. Treherne, and H. P. Birch, Medical Staff.

ADMIRALTY.—The following appointments have been made:—Staff Surgeon John Wilson, to the *Cormorant;* Arthur Keess, Esq., M.R.C.S., to be Honorary Surgeon to the Royal Naval Artillery Volunteers (London Brigade).

MILITIA MEDICAL STAFF.—Surgeon-Major Charles Wm. Marriott, 4th Battalion, the Royal Warwickshire Regiment, resigns his commission; also is permitted to retain his rank, and to wear the prescribed uniform on his retirement; Surgeon Herbert Goldingham Budd, 3rd and 4th Battalions, the Worcestershire Regiment, to be Surgeon-Major; Surgeon Duncan McFadyen, 2nd Battalion, the Queen's Own Cameron Highlanders, to be Surgeon-Major; Surgeon James Ramsey, M.D., 3rd Battalion, the Prince of Wales's Own (West Yorkshire Regiment), to be Surgeon-Major.

YEOMANRY CAVALRY.—Cheshire: Surgeon William Chas. Watson resigns his commission.

ARTILLERY VOLUNTEERS.—1st Cinque Ports: Captain Alfred Sparkes resigns his commission; Acting Surgeon Thomas Horne, M.D., resigns his appointment.—1st Worcester: William Herbert Packer, Gent., M.D., to be Acting Surgeon.

RIFLE VOLUNTEERS.—2nd Volunteer Battalion, the Lincolnshire Regiment: Thomas Porter Greenwood, Gent., to be Acting Surgeon.—10th Lanarkshire (Glasgow Highland): Quintin Chalmers, Gent., to be Acting Surgeon.—11th Middlesex (Railway): Isaiah George Butters, Gent., to be Surgeon.—3rd Lancashire: William Deans, Gent., to be Acting Surgeon.—1st Cinque Ports: John James Marshall, Gent., to be Acting Surgeon.

HOSPITAL FOR SICK CHILDREN.—At the thirty-third annual meeting of the governors of this institution on the 20th inst. it was stated that the number of in-patients admitted during the past year was 932, and that the out-patients receiving advice and medicine were 15,270. At the Convalescent Hospital, Highgate, 249 children had been received. The available income amounted to £9844, including legacies to the amount of £1650. The expenditure at both establishments amounted to £11,471, which included a portion of the outlay on alterations.

Correspondence.

"Audi alteram partem."

"PNEUMOTHORAX FOR HÆMOPTYSIS."

To the Editor of THE LANCET.

SIR,—My object in trespassing upon your space is not to enter into the important question of the therapeutic value of the mode of treatment advocated by Dr. Cayley in his most interesting communication to the Clinical Society on the above subject, but simply to discuss how far the special method adopted by him is calculated to secure the desired end, the collapse of the lung; and I therefore venture to ask, What reason have we to believe that free incision into the pleural cavity through the chest wall is necessarily followed by collapse of the lung?

Theoretically, the desired result should be attained; when the atmospheric pressure acting through the larynx is neutralised by the pressure of the air upon the outer surface of the lung, the elastic force of the lung should be set at liberty to produce complete collapse of the organ and to restore it to its fœtal condition. "Thus," according to Hermann,[1] "should, through any opening, air pass into the space between the lungs and the thoracic walls, then the lungs by virtue of their elasticity collapse to their natural (atelectic) volume (pneumothorax)."

I venture to submit, however, that collapse of lung by no means necessarily follows the free admission of air into the pleural cavity. This has long been fully recognised. Mr. Erichsen, for instance, says,[2] "Collapse of the lung in wounds of the chest consequent upon the action of the atmospheric pressure upon the outside of the organ, has been more frequently spoken about than seen. The chest may be largely opened, and the full pressure of the atmosphere allowed to act on the outer surface of the lung, and yet no collapse of this organ takes place. The lung in such cases may be seen rising and falling at the bottom of the wound." In my own experience this is just what occurs when the thoracic cavity is freely opened in the treatment of empyema; in such a case the lung, provided that it is not bound down by adhesions, may be plainly seen rising and falling during respiration, just as described by Mr. Erichsen in the case of primary wound of the pleural cavity. When the opening is first made, indeed, the violent expulsion of the pus and the irritative cough dependent upon rapid expansion of the lung plainly indicate that what is taking place is the very opposite of collapse of the organ.

If it were a fact that free incision into the pleural cavity necessarily produced collapse of lung, the operation for the cure of empyema would be an exceedingly grave undertaking, on account of its inevitable after-effects. For since, on the one hand, the lung could not expand to meet the chest wall, and thus obliterate the pus cavity, unless the external opening were closed, and, on the other, the abscess cavity could not become obliterated unless the aperture were left open to allow of free drainage, it would of necessity follow that in the large proportion of cases the patients would be left with a lung in a condition of complete and permanent collapse and a chronic fistulous opening into the pleural cavity. It is well known, however, that such a result is not met with except in the most unfavourable cases, when the lung is already bound down by adhesions and the chest wall cannot fall in to the requisite extent.

Collapse, or, more correctly, compression, of lung as the result of pneumothorax occurs with certainty only when the air is pent-up in the pleural cavity; when it enters with inspiration and does not escape with equal freedom during expiration; and it is consequently met with by far the most often when perforation of the cavity occurs from the lung, in the absence of any free external opening; and it is well known that the urgent symptoms produced by such a condition may be at once relieved by thoracentesis, by which procedure the pressure of the air in the pleural cavity is reduced to that of the atmosphere.

A careful consideration of the details of the very important case brought forward by Dr. Cayley shows that the collapse of lung which was actually found post mortem may be explained in accordance with the above theory. For it is noted that during the treatment of the case the tube became blocked and pleurisy with effusion set in. The physical conditions for the induction of compression of lung were thus established.

I would therefore submit that if it is desired to produce collapse or compression of lung, air should be injected into the pleural cavity, as proposed by Mr. R. W. Parker and commended in your remarks upon the subject, rather than admitted by a free external opening, in order that a compressing force greater than that of the atmosphere may be secured, and the collapse of the organ may thereby be rendered certain.—I am, Sir, your obedient servant,

E. MARKHAM SKERRITT, M.D.Lond., F.R.C.P.,
Senior Physician to the Bristol General Hospital.

Clifton, May 26th, 1885.

[1] Human Physiology, translated by Gamgee, p. 159.
[2] Science and Art of Surgery, vol. i., p. 494.

THE TITLE OF "DOCTOR" FOR LONDON MEDICAL STUDENTS.

To the Editor of THE LANCET.

SIR,—The proposal of the Royal College of Surgeons to obtain power, in conjunction with the College of Physicians, to grant the title of "Doctor" to their licentiates and members in future must be unitedly opposed by graduates of recognised universities. Granted that there is a commercial value to the title, it would be manifestly unfair to those who have obtained it in a legitimate way to sow it broadcast in this manner. Of course, it is easy to see that it is the unblushing way in which the Licentiates of the Edinburgh and Glasgow Corporations have taken to themselves the title (which it has been proved does not belong to them) which has provoked the above resolution. Surely it is beneath the dignity of our English Colleges to follow in the footsteps of their unworthy compeers! What compensation is to be given to those who have taken the extra trouble and gone to considerable extra expense to gain a university degree in addition to the Membership of the College? Ought not a still higher title to be granted them, or else some distinguishing mark by which the public can gauge the different value of their "Doctorate"? Of course, to the public every medical man, from the lowly L.S.A. to the magnificent F.R.C.P., and consulting physician, is "doctor," in the same way that to the Irish peasantry every military man is "captain." If it be required that all medical men should start with equal degree in rank, baronetcies should be conferred on all, for there is no doubt of the extra commercial value of that title to medical men, and although this distinction has also been gained (by those medical men who hold it) by extra work, zeal, or skill, why should this levelling down process only begin at "doctor"?

Let the Council of the College admit their members to a share in its government, and alter its constitution, if necessary, to allow of this, and they will be doing a great work; but, as a member, I beg to protest against this attempt to destroy the value of university titles gained by those who have taken the extra trouble and work to procure them.

I am, Sir, yours truly,

C. ST. JOHN WRIGHT, M.B.Aberd., &c.

St. Mary Infirmary, Islington, May 26th, 1885.

SMALL-POX RISKS AND REVACCINATION.

To the Editor of THE LANCET.

SIR,—With reference to Mr. Goude's letter in your issue of the 16th inst., on the above subjects, and the paper read before the Society of Arts on the 8th inst., if you will kindly give me a little space in an early issue I shall be very happy to place before the profession, by means of your columns, the reasons which led me, as Mr. Goude puts it, to "publicly state his [my] disbelief in the necessity for revaccination in adults who have been efficiently vaccinated;" and to prohibit the practice of revaccination in the system of voluntary vaccination inaugurated by me in the first circle of the North-West Provinces in India in 1864. The practical experience and personal observation of thirty years' service in India, the home of small-pox, with the last twenty years of that service, I may say, almost entirely devoted to the subject of ascertaining the best prophylactic for small-pox, have satisfied me that no prophylactic can even approach vaccination; and when it is carefully supervised, and skilfully practised, and the system known as arm-to-arm vaccination, or what really amounts to it,

alone carried on, there is no necessity for revaccination. My opportunities for arriving at any conclusion on this most important subject will, I think, be allowed to be extensive and special, when I state that, during the last twenty years of my Indian service, I have been continuously engaged in vaccination in one sanitary circle, with a population of ten millions and an average of 500 to the square mile—with my vaccine work standing the test of small-pox as an annual visitor—with no attempt at isolation even in sporadic cases; on the contrary, with the promiscuous collection of cases of the disease in every stage of the eruption, with children, as yet free from it, at the shrine of the goddess of small-pox, "Sutla." Here, in the midst of all this small-pox contagion and infection, I have never protected (if I may use the term) my work by revaccinating a single native youth or adult, or permitted one of my two hundred subordinates to do it. If, therefore, revaccination is necessary in this country owing to the prevalence of small-pox among the vaccinated, I can point to towns, cities, and districts where small-pox is practically unknown, except in a few isolated unvaccinated cases, and ask, Why this difference? I will not, however, take up more of your space at present. All I ask from the numerous professional and unprofessional readers of your journal is a hearing and an opportunity of showing that Jenner's great discovery has gained by the lapse of time; and that in India it has by its own merit overcome every possible difficulty, and is gratefully accepted in the place of inoculation by a nation who have practised that prophylactic from time immemorial. I am, Sir, yours faithfully,

R. PRINGLE, M.D.,
Late Sanitary Department, H.M.'s Bengal Army.

Blackheath, S.E., May 19th, 1885.

THE NEW LUNACY BILL.

To the Editor of THE LANCET.

SIR,—Without venturing an opinion on any of the points touched upon by the Lord Chancellor's new Bill, I would beg to direct your attention to a matter not therein referred to, and which, I think, calls as loudly as any other for reform. I refer to the power at present vested in the magistracy of sending a pauper lunatic to any other asylum in England than that in his own county should there not be room for him in the home establishment. Under this law hundreds of unfortunates are annually conveyed to far distant parts of the country. Their friends are poor, and have neither the time nor the money necessary for their visitation. So pauper lunatics are left in their affliction to mourn their unhappy lot; to live, and probably to die, in the midst of strangers, and to suffer in their declining years that feeling of desertion and utter loneliness which was until now supposed to be reserved for the criminal. The Commissioners in Lunacy expressed their disapproval of the system some years back, saying that it was the cause of very great hardship to the patients so transferred. Could not a clause be inserted in the Bill at present being considered making it compulsory that pauper lunatics should be kept and treated within the counties in which they are chargeable as paupers?—this to come into force at the expiration of a reasonable time, to allow of extra accommodation being provided when required. It is surprising that this matter has not yet been mentioned in connexion with the new Bill, seeing that it entails more misery and hardship upon the transported lunatic (and his friends) than almost any other provision of the existing lunacy laws.

I am, Sir, yours faithfully,

May 24th, 1885. S. A. K. STRAHAN, M.D.

"PERSONAL EXPERIENCE OF COCAINE AS AN ANÆSTHETIC."

To the Editor of THE LANCET.

SIR,—In last week's issue you publish a letter from Mr. Wm. Copeland, M.R.C.S., of Staindrop, near Darlington, headed as above. In this letter Mr. Copeland states his belief that "he is the first member of the profession who has undergone a serious operation under the influence of the new anæsthetic." Whilst I sincerely congratulate Mr. Copeland upon the success of his case and Dr. Bell Taylor in having such an able advocate, I would point out that, in this neighbourhood at all events, Mr. Copeland is not the first member of the profession who has been operated upon for senile cataract under the influence of cocaine.

In February last I operated upon Dr. Welford, an eminent and much respected member of our profession in Sunderland. Dr. Welford, who perhaps at some future time may be induced to give his experience of the new drug, suffered no pain, and is now in the enjoyment of perfect eyesight.

I am, Sir, yours truly,

CHRISTOPHER S. JEAFFRESON.

Newcastle-on-Tyne, May 26th, 1885.

DEAR DR. JEAFFRESON,—I have just been told THE LANCET of last week publishes a case (Mr. Copeland, of Staindrop) as the *first* operation on a medical man in the north for removal of cataract under the influence of cocaine. Now, if this was done subsequent to Feb. 15th, 1885, it is *not* the first, for on that day you operated on my eye under cocaine, and successfully removed, without the slightest pain whatever, a cataract, "its success manifest in my writing this letter." With many thanks for your great kindness and skilful manipulation,

Believe me, dear Doctor, yours sincerely,

GEORGE WELFORD.

Cotherstone, Darlington, May 25th, 1885.

IRELAND.

(From our own Correspondent.)

HONOURS FOR THE MEDICAL PROFESSION.

THE rumours that several members of the profession in Dublin would receive distinctions from the Government appear to have been without foundation. The visit of the Prince of Wales to this country was a most successful one, and all classes vied with each other to make his stay agreeable. That they succeeded is conceded on all hands, and naturally it was expected by the profession here that the visit would have been marked by distinctions being conferred on some leading members of the medical profession. The honours, however, appear to have been doled out with no liberal hand. Dr. Wycherly, it is true, has been knighted; but this distinction was conferred solely on account of his holding the office of High Sheriff for the city of Cork. It may be argued that these matters rest with the Prime Minister, and not with the Prince of Wales. This may be correct; but, on the other hand, there can be no doubt that the slightest wish of His Royal Highness in these matters would at once have been attended to. At all events, the medical profession here must feel itself slighted at the indifferent manner in which it has been treated by the authorities.

HOUSING OF THE POOR COMMISSION.

On Saturday last the Royal Commission appointed to inquire into the housing of the working classes in Dublin commenced its duties under the presidency of Sir C. Dilke, M.P. The witnesses examined included the officers of the Local Government Board, the chairman of the Public Health Committee, Dr. Cameron, medical officer of health, and others. The proceedings, being private, cannot be published at present; but complaints have been made that the examination of four witnesses was conducted simultaneously, and that sufficient time was not devoted to the hearing of evidence by such an important Commission. It has also been alleged that although important evidence was tendered on the first day, it was declined on the ground of being "too late." Another sitting was held on Tuesday, but if carried out in the same manner, little good can be expected from its labours.

CORK SOUTH INFIRMARY.

The trustees of this infirmary have advertised for two surgeons and a physician, to be appointed on June 12th next, in accordance with a rule of the institution, which states that all officers of the staff appointed after 1876 shall cease to hold office at the end of five years, but shall be eligible for re-election. The objections to such an arrangement are many and manifest, and consequently the medical practitioners in Cork have recently held a meeting to take into consideration the question of these vacancies. The meeting appears to have been undivided in its opinions, as the resolutions were unanimously adopted. These resolutions

stated that the medical profession in Cork considered the system of electing the staffs of the various hospitals for a limited period would tend to lower their status; and that no medical man should oppose the re-election of any member of a hospital unless he had been neglectful of his duties. These resolutions have been brought under the notice of the trustees of the infirmary.

ADELAIDE HOSPITAL.

The late Mrs. Bolton of Bective Abbey, County Meath, has bequeathed to this institution a perpetual rent charge of £400 a year, to be applied to the maintenance of some distinct ward or branch of the hospital, and to be called the "Bolton Donation."

A MORGUE FOR KINGSTOWN.

Kingstown, a seaport town some seven miles distant from Dublin, is greatly in want of a morgue for holding inquests, and as a receptacle for the bodies of persons found in the harbour. The coroner for the district has on several occasions drawn attention to the disgraceful neglect in providing such a building, but up to the present without success. The commissioners of the township are, I understand, the responsible authorities, and it is to be hoped they will take the necessary steps without delay to supply the defect.

The Earl of Rosse has been elected Chancellor of the University of Dublin.

On Monday last the Lord Mayor of Dublin formally opened the new baths and washhouses in Tara-street, which have been erected at a cost of £5000.

Dublin, May 26th.

PARIS.

(From our Paris Correspondent.)

THE LATE PROFESSOR BOUILLAUD.

THE statue that was erected in honour of Professor Bouillaud at Angoulême, his native town, was unveiled on Saturday, the 16th inst., in the presence of the notabilities of the place and of several members of the profession from Paris and elsewhere, most of whom were pupils of the illustrious physician. There were also present delegates from the various learned societies to which Dr. Bouillaud belonged—Professor Vulpian representing the Academy of Sciences, Dr. Henri Roger the Academy of Medicine, and Professor Laboulbène the Faculty of Medicine of Paris. In the most emphatic language the orators retraced the professional life of Dr. Bouillaud, commencing from his doctorate to the day of his death. He had scarcely left the school of medicine when he made an important discovery, showing the parts played by phlebitis, and the obliteration of the veins, in the production of certain forms of dropsy. He was not quite thirty years of age when he published his treatise on Encephalitis, in which he affirmed that the seat of articulate language is in the anterior lobes of the brain; at forty he published his Medical Nosography. His works on Essential Fevers, Medical Philosophy, and Acute Articular Rheumatism (in the latter of which he established the law of coincidence of inflammation of the sero-fibrous membranes of the heart, which opened a new field to pathology), and his treatise on Diseases of the Heart are sufficient to place Bouillaud among the members of the profession of the present century who have contributed by their works to create a new era in the practice of medicine. In 1826 he was promoted to agrégé of the Paris Faculty of Medicine; in 1825 he became member of the Academy of Medicine; in 1831 he was appointed hospital physician, and in the same year to the professorship of Clinical Medicine, which he occupied for nearly half a century with so much credit to himself and advantage to his pupils, who are now scattered over all parts of the civilised world. He was also a member of the Academy of Sciences.

THE ELIMINATION OF ARSENIC.

At the last meeting of the Paris Society of Medical Jurisprudence, Professor Brouardel reported a case illustrating the possibility of an infant at the breast being poisoned through its mother's milk. In his capacity of medical jurist he was consulted about a case which was lately brought before the tribunal, in which a man was accused of having attempted to poison his wife with arsenic, which he gave her in her food, she having at the same time a sucking baby. The infant was seized with symptoms of cholerine a few days after the mother had been affected in a similar way—diarrhœa, vomiting, &c., from which it died. These symptoms having occurred during the hot season, no importance was attached to them; but in the month of November following, the wife and mother-in-law of the accused having been again similarly affected, suspicions were aroused, and Professor Brouardel caused the body of the infant, which had been buried six months, to be exhumed. According to the Professor's report, the body was completely transformed into cadaverous fat, and it was impossible to isolate the viscera from the other parts, so that the body had to be analysed *en masse*. It weighed about two and a half kilogrammes, and contained five milligrammes of arsenic. Means had been taken to make sure that the arsenic did not come from the linen enveloping the corpse, nor from the earth which surrounded the coffin. The question then suggested itself as to whether the arsenic found in the body of the infant might not have been eliminated by the milk of the mother. To ascertain the possibility of such a circumstance, M. Gabriel Pouchet performed some experiments which were very conclusive. He administered to a certain number of wet-nurses, who were in the St. Louis Hospital affected with skin diseases, from two to twelve drops of Fowler's solution, and he ascertained that in these conditions the milk of the nurses always contained a relatively large quantity of arsenic; thus, the milk of one nurse, who had taken eight milligrammes of arsenic in six days, contained one milligramme of the metalloid to 100 grammes. M. Pouchet observed that these doses did not affect the nurses or their nurslings in the least. But upon the suppostion that the result might be otherwise if a large dose of the arsenic were administered at once, and in order to clear up this point, M. Pouchet tried experiments on some females among the lower animals. This series of experiments did not furnish conclusive results, as animals present a variable degree of susceptibility to arsenic, and it was therefore impossible to draw any comparative conclusions. It may, however, be deduced from these researches that the elimination of arsenic takes place principally through the milk, and it is therefore prudent never to administer arsenic to mothers suckling infants.

Paris, May 26th.

EGYPT.

(From a Correspondent.)

THE annual examinations at the Egyptian School of Medicine began on May 16th, and were attended on that day by his Highness the Khedive, all the Ministers, the Cadi, the Sheikh el Islam, and a few other visitors. The lecture theatre, which bears on its walls the names in Arabic of Hippocrates, Galen, Æsculapius, Asclepias, Dupuytren, Nélaton, Morgagni, and other classic names, together with those of some Oriental celebrities unknown to English ears, was luxuriously decorated in honour of the occasion. A fifth year's medical student was orally examined before the Khedive, then followed a fifth year's pharmaceutical student, who very rapidly discovered that three previously unknown solutions contained bichloride of mercury, acetate of lead, and nitrate of silver. Lastly, a Mussulman pupil midwife, closely veiled, was examined *viva voce* in her art, and was even made to apply the forceps to the dummy before the august assembly. The Khedive was then conducted over the new museums, which are a valuable nucleus for the future, and show a considerable improvement over their condition twelve months ago. One large room now contains valuable acoustic and other physical instruments, which were recently discovered packed away in an old storehouse, and are probably relics of gifts to the medical school in olden days by Dr. Clot Bey and Napoleon III. A medical tourist who recently visited Cairo has exposed the nakedness of the school of medicine in no sparing terms, but a glance at the accompanying figures will show that it is unfair to blame the professors for not providing efficient laboratories and museums. It will be seen that the whole income for the three combined schools of medicine, pharmacy, and midwifery reaches only £14,914, of which £2175 remain after paying for

salaries and for the food and clothing of the students. Very little reform can be effected with this absurdly small sum.

School of Medicine and Pharmacy.		
Director	£900	
23 Professors and Assistants	5730	
35 Servants	866	
Food for Male Students	734	
Various Expenses	148	
		8378
School of Midwifery.		
4 Professors	282	
5 Servants	67	
Food for Female Students	167	
Various Expenses	8	
		524
Clothes for all Students	3993	
Teaching Materials	1837	
Furniture	90	
Small Expenses	92	
		6012
Total		£14,914

The income has been this year summarily reduced by £3000 in consequence of the general financial reform in Egypt, and it is greatly to the credit of the Director of the School that any of the recent improvements have taken place. He has succeeded in obtaining leave to spend £1000 this year on scientific instruments for laboratories, and it is to be hoped that the order which has already gone to Paris will contain elementary instruments of practical value, instead of being spent entirely in costly microscopes for demonstrating bacilli. Plans for building additional museums have also been drawn out, and £2000 of the necessary £10,000 has this year been placed at the disposal of the school authorities. It is satisfactory also to note that out of 150 students at present in the school 75 now pay £14 a year for the privilege of being educated. Formerly the Government bore the expense of all students, as their parents being mostly of the peasant class were unable and unwilling to contribute anything towards their education. Much unostentatious good work is being done at Kasiel Ain Hospital, which adjoins the Medical School. Mussulman women nurses are being trained for the first time, a system of house-surgeons and dressers has been started, and sawdust and corrosive sublimate dressings have taken the place of charpie and commercial carbolic acid. A new women's ward has been opened, and an operating theatre has been commenced, which will prove a great boon to both surgeons and students. During the last week the following interesting cases were admitted into the surgical wards:—

CASE 1. A Soudanese, who stabbed himself in the abdomen after an unsuccessful attempt to shoot an English soldier who passed him in the street. This man, when brought to the hospital, had three coils of large intestine, about two feet and a half in length, outside his abdomen, These were cleaned and returned, and he is recovering without a bad symptom. He probably consumes opium or hasheesh, and it is interesting to note that he required almost a gramme of opium in twenty-four hours to be put under the influence of the drug.

CASE 2. An Egyptian woman was brought in suffering from omental hernia without any covering, which had been exposed for a week, but had given rise to no abdominal symptoms. This patient was found walking about in the ward the day after the operation, and is rapidly recovering.

CASE 3. A fracture of the surgical neck and dislocation of the head of the humerus, not seen until three days after the injury. The dislocation was very easily reduced under chloroform.

At the beginning of this month a weak strumous child was operated on for swollen cervical glands at the earnest wish of its parents. On the seventh day after operation hæmorrhage occurred from a small branch of the external carotid, and this was readily controlled by the thumb of the native "probationer" nurse, who had only been under Dr. Milton's training for four months. The midwife when summoned also applied direct pressure to the wound, and was intelligent enough to refuse offers of perchloride of iron from a house-surgeon. When Dr. Milton arrived in the ward, he found the child pulseless and moribund. Injections of ether and other treatment proving useless, he at once bared his own elbow, drew off a sufficiency of blood, and injected it into the jugular of the patient, unfortunately not saving the child's life. Such a lesson as this is incalculably of more value to student doctors and nurses than any of the prolonged efforts of memory which most school teaching in Egypt requires, and it is by such individual acts of courageous self-sacrifice that the good name of Englishmen in Egypt is sustained, and a counterpoise may perhaps be effected to the unfortunate feebleness of administration of England in this country.

Cairo, May 20th.

ROYAL COLLEGE OF PHYSICIANS.

AN extraordinary Comitia of the College was held on the 28th inst., Sir W. Jenner, Bart., President, in the chair. The gentlemen nominated at the last meeting, and whose names appeared in our impression of the 2nd instant, were duly admitted to the Fellowship. The late Dr. John Thorburn of Manchester was one of the gentlemen elected, and sympathetic reference was made to the fact of his death by Dr. Priestley, on whose motion the College resolved to address a letter of condolence to the widow.

A letter was read from the Secretary of the Royal College of Surgeons with respect to the appointment of seven delegates from each College to confer on the question of granting the title of "Doctor" to persons who shall have obtained the licence of the College of Physicians and the diploma of the College of Surgeons. A memorial was also presented by Dr. W. Hickman, urging the desirability of a complete conjunction between the Colleges. The President nominated Dr. Wilson Fox, Dr. Ord, Dr. Norman Moore, Dr. Moxon, and Sir Andrew Clark, Bart., with the President and Registrar, to act as delegates from the College.

On the motion of Dr. Norman Moore, it was resolved to guarantee the sum of 200 guineas towards the expenses of publication of the manuscript notes (1616) of Harvey's Anatomical Lectures.

The consideration of the Report of the Council upon the Croonian Trust was resumed. It recommended that "the residue of the income from the Trust, after payment of the Croonian Lecturer, be invested, to form a fund for the establishment of a Professor of Anatomy and Physiology, the person holding such professorship to be called the 'Croonian Professor of Anatomy and Physiology,' and to hold such professorship for five years." After some debate the Report was referred to a Special Committee, consisting of the Members of the Council and those Fellows who had given notice of amendments.

A Report was read from a Committee upon the Lunacy Bill, especially in reference to the question of the signing of certificates in lunacy, and a discussion ensued.

MEDICAL NOTES IN PARLIAMENT.

Medical Officers of Irish Prisons.

IN the House of Commons on the 21st inst. Mr. Hibbert, in reply to Mr. Macartney, stated that the medical officers of Her Majesty's prisons in Ireland who gave evidence before the late Royal Commission received the same allowances as those paid to medical officers appearing as witnesses before other commissions and select committees. These allowances were calculated to cover professional losses, and that included the payment of a substitute where necessary.

Medical Act Amendment Bill.

Mr. Mundella, in reply to Mr. A. O'Connor, stated that he was not aware of any intention on the part of the Government to reintroduce the Medical Act Amendment Bill of last session, and was understood to add that he did not think such a step was probable.

Protection against Cholera.

On the 22nd inst., in reply to Dr. Cameron, Mr. G. Russell stated that he was aware that Dr. Ferran was testing at Alcira the efficacy of vaccination as a remedy against cholera, and he had seen a telegram from him containing a statement as to the facts contained in the question, and asking that a commission should be sent out. The Local

Government Board was considering whether it could comply with the request; but the telegram was only placed in his hands on the 21st inst., and there had been no time to come to a decision in the matter. If the Department thought it desirable to send out a commissioner, he would undertake to bring the matter under the notice of the Secretary of State for India, as India was even more interested than England in the prevention of cholera.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen passed the first part of the Professional Examination for the Fellowship at a meeting of the Board of Examiners on the 25th inst.:—

Edmund Vaudrey, St. George's and Edinburgh; James T. James, Middlesex; J. Bowring Lawford, McGill and St. Thomas's; Henry J. Blakesley, Birmingham; A. F. Gambell Codd, St. George's; Robert Heelis, St. Thomas's; Harry Littlewood, University College; Charles S. Blair, Newcastle and London.

(Candidates referred, 12.)

Passed on the 26th inst:—

G. Adlington Syme, Melbourne and King's College; Alfred H. Tubby and A. Sneyd Taylor, Guy's; A. Ward Collins, University College and Liverpool; Robert T. Kent, Edinburgh and Guy's; John W. Smith, Edinburgh; Leonard A. Bidwell, St. Thomas's; A. Hancock Middleton, Dublin; Hugh Smith, London and Guy's.

(Candidates referred, 11.)

Passed on the 27th inst.:—

W. H. Breffit Brook and Wilfred Balgarnie, St. Bartholomew's; Henry P. Dean and Cyril W. Jecks, University College; Walter R. Jordan, Birmingham; Francis S. Hawkins and H. Evelyn Crook, Guy's; Arnold F. Bradbury, Newcastle; William H. Tomlinson, Manchester; William R. Ackland, Charing-cross; Ernest Solly, St. Thomas's.

(Candidates referred, 9.)

The library of the College is closed for the present for the purposes of the Fellowship Examination. The lectures will be resumed on Monday, June 1st, by Professor Edward Lund, F.R.C.S., the subject being "Some of the Injuries and Diseases of the Head and Neck, the Genito-Urinary Organs, and the Rectum."

SOCIETY OF APOTHECARIES.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on the 21st inst.:—

Jones, Oliver Wentworth, Madras Medical College.
Roberts, Hugh Jones, Guy's Hospital.

The following gentleman passed his examination in the Science and Practice of Medicine, Surgery, and Midwifery, and received a certificate to practise on the same date:—

Mallet, Thomas Charles, St. George's Hospital.

ON the 27th inst. Sir Charles Dilke addressed a crowded meeting of the Ladies' Sanitary Association at Dublin.

THE Queen has appointed John Foreman, Esq., medical officer of the Virgin Islands, to be a member of the Executive Council of those islands.

A MEETING, under the presidency of the Bishop of Bedford, was held on the 20th inst., for the purpose of aiding the East London Nursing Society.

IN the case of Page *v.* Harrison an order was recently made by the Divisional Court for a new trial, on the ground that the verdict for the plaintiff of £150 damages was against the weight of evidence. In the Court of Appeal on the 21st inst. the decision of the Divisional Court was affirmed.

CHARING-CROSS HOSPITAL.—The Queen has contributed a special donation of £50 towards the Triennial Festival Fund now being raised at Charing-cross Hospital for providing accident wards, a children's ward, and other improvements. The triennial festival dinner was held on the 20th inst. During the evening subscriptions amounting to about £6500 were announced.

SOCIETY FOR TRAINING TEACHERS OF THE DEAF.—The annual general meeting of this Society is to be held at the Training College, Elmhurst, Castlebar-hill, Ealing, to-day (Saturday). At 4 P.M. the annual exhibition of the pupils of the school will take place, when an opportunity will be afforded to visitors of witnessing the method of instruction and noting the progress of the pupils.

THE medical superintendent of the hospital ships *Atlas* and *Castalia* has issued a report regarding the work carried out on these ships in the treatment of small-pox patients in the metropolis.

AT the annual court of the governors and subscribers to the Victoria Hospital for Sick Children it was stated that the cost of the additional building decided upon would be about £4500, and of this amount only £3000 has as yet been collected.

PRESENTATION.—On the 15th inst. a marble time-piece with bronze side ornaments, and an illuminated address, subscribed for solely by the working classes of Darlington, were presented to Dr. Hern, late house-surgeon at the Darlington Hospital.

IT is stated on authority, says the *Australian Medical Journal*, that for the year ending December 31st, 1883, out of 11,173 births in South Australia, 9895 were successfully vaccinated, as shown by fees paid for returns. This is equal to 88·5 per cent. of registered births.

UNIVERSITY OF CAMBRIDGE.—At a congregation held on the 21st inst. the following degrees were conferred:—Doctors of Medicine: William Collier, Jesus; Edward Ground, Downing. Bachelor of Medicine: William Foster, St. John's. Bachelor of Surgery: Alfred Francis Street, Trinity.—Mr. Henry Tempest Dufton has been elected to the Tancred Studentship in Physic at Gonville and Caius College.

NORTH-EASTERN HOSPITAL FOR CHILDREN.—From the report which was read at the seventeenth annual meeting of the supporters of this institution on the 18th inst., it appears that during last year the number of in-patients treated was 620, and the out-patients 14,249, as compared with 637 in-patients and 14,548 out-patients in 1883. The income of the hospital during the year from all sources, except legacies, amounted to £4225 being an increase of £65. The decrease of expenditure was about £70, taking into consideration outstanding accounts on Dec. 31st, 1884. Last year a debt was due to the bankers of £4000, which had been reduced this year by £200.

AT a meeting of the Holbeach Board of Guardians on the 8th inst., Dr. O'Meara, medical officer to the Sutton Bridge district, applied for an increase of salary. The applicant stated that his salary was £20 per annum, or a little more than 7*s.* a week. In his district there were forty paupers entitled to his services, and his patients of that class averaged ten per week and thirty bottles of medicine. The district was a scattered one, and he was compelled to drive hundreds of miles in the year to fulfil his duties. If a case occurred in one portion of the district needing daily attendance, he would be compelled to drive seventy miles a week, and expend 14*s.* a week in bridge tolls. The board declined to grant an increase.

UNIVERSITY COLLEGE.—The distribution of prizes to the successful students in the Faculty of Medicine at this institution took place on the 20th inst. The following are the principal awards:—Herbert Caiger obtained an entrance exhibition of £100, H. M. Fernando one of £60, and S. K. J. Brock one of £40. The Atchison scholarship was obtained by Raymond Johnson, as was also the Bruce medal. C. J. Arkle was awarded the Atkinson-Morley scholarship, and H. P. Dean the Cluff prize. In Practical Surgery, the Erichsen prize was obtained by E. H. Thane. In Physiology, G. E. Rennie, in the senior class, was awarded the gold medal, and C. H. Fernau and J. P. Parkinson silver medals, while in the junior class H. M. Fernando obtained a silver medal. G. E. Rennie obtained the gold medal in Anatomy, and C. H. Fernau and J. P. Parkinson silver medals, and in the junior division G. White was awarded a silver medal. In Medicine, F. W. Burton obtained the gold medal, and H. H. Brown and S. E. Holder silver ones. Raymond Johnson received the gold medal in Surgery, and E. H. Thane a silver one. In Practical Chemistry, H. W. Picton was awarded the gold medal; H. H. Cayley and H. B. Kitchin, silver medals. The Tuke medal in Pathological Anatomy, was awarded to Raymond Johnson. E. H. Thane received the gold and Raymond Johnson the silver Fellowes medals in Clinical Medicine; F. W. Gee obtaining a silver medal in the junior class. In Clinical Surgery, J. J. Lister obtained the Liston medal, and in Clinical Dental Surgery Raymond Johnson was awarded a prize.

NORTH-WESTERN ASSOCIATION OF MEDICAL OFFICERS OF HEALTH.—At the monthly meeting of the members of this Association on the 14th inst. it was resolved, with regard to Mr. Phythian's paper on "Tenure of Office by Medical Officers of Health," that the hon. secretary should communicate with the Metropolitan Society of Medical Officers of Health and the Yorkshire and Midland Association, with a view to some united action being taken to remedy the unsatisfactory position of medical officers in this respect, and to suggest the formation of a joint committee to secure the desired alteration, and to ensure that such alteration should be embodied in any measure of local government reform introduced before Parliament. Mr. Vacher then read a paper on "The Inspection of Meat Markets," and a short discussion followed.

BRISTOL MEDICAL SCHOOL.—The annual exhibition of prizes to the students of this school took place on the 18th inst. The principal awards were as follows:—Summer Session: Practical Chemistry, Mr. Henry Hamilton. Practical Physiology and Histology, Mr. Frederick Lace. Botany, Mr. Theodore Mayo Stiles; Lecturer's Prize, Mr. Herbert John Thomas. Materia Medica and Therapeutics, Mr. John Henry Fardon; Lecturer's Prize, Mr. Henry Hamilton. Obstetric Medicine, Mr. Herbert Alfred Burleigh. Practical Surgery, Mr. Francis Frederick Jones. Medical Jurisprudence, Mr. Alfred John Tomkins. Winter Session: Anatomy and Physiology (junior classes), Mr. Samuel Wolferstan Morgan. Senior Class of Anatomy, Mr. Theodore Mayo Stiles. Senior Class of Physiology, Mr. Theodore Mayo Stiles. Practical Anatomy, Mr. F. Lace. Chemistry, Mr. Chas. Meaden. Medicine, Mr. W. C. Swayne. Surgery, Mr. Harless Frederick Semple and Mr. Walter Carless Swayne (equal).—Bristol Royal Infirmary: Suple Medical Prize, Mr. John Ernest Trask. Suple Surgical Prize, Mr. Charles Edward Stuart Flemming. Crosby Leonard Prize for Proficiency in Surgery, Mr. John Ernest Trask. Tibbits Memorial Prize, Mr. William Connor Lysaght. Clarke Prize, Mr. Henry Frederick Semple. Pathological Prizes, Mr. Charles Edward Stuart Flemming and Mr. John Ernest Trask (equal).—Bristol General Hospital: Martyn Memorial Entrance Scholarship, Mr. Wm. Henry Ware. Clarke Scholarship, Mr. Wilfred Martin Barclay. Sanders Scholarship, Mr. Arthur Nicholas Little and Mr. John Bartlett Webb (equal). Lady Haberfield Prize, Mr. John Bartlett Webb.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning at the latest.*

BEDDOES, T. P., M.R.C.S., has been appointed Clinical Assistant in the Skin Department, St. Thomas's Hospital.

BURFORD, GEO. HENRY, M.B., C.M.Aber., has been appointed Assistant Medical Officer to the Crumpsall Workhouse and Receiving Wards, New Bridge-street, Township of Manchester.

EDLIN, HOLBERTON, F.R.C.S.Ed., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer of Health for the Compton-Gifford Urban Sanitary District, Devonshire.

ELDER, GEORGE, M.D., C.M.Glas., has been appointed Surgeon to the Samaritan Hospital for Women, Nottingham.

EVANS, ROBERT, M.R.C.S., L.R.C.P.Ed., has been appointed Assistant Medical Superintendent to the Hackney Union Infirmary, vice Dr. Fuller, resigned.

GORDON, T. E., M.B.Dur., has been appointed Resident Surgeon to the Birmingham General Dispensary, vice H. Shillito, M.B.Lond., resigned.

GREEN, C. D., M.B., L.R.C.P., M.R.C.S., has been reappointed House-Surgeon to St. Thomas's Hospital.

GRIFFITH, A. HILL, M.D.Aberd., has been appointed Assistant-Surgeon to the Manchester Royal Eye Hospital.

HARRIES, ARTHUR, M.D., Senior Assistant-Physician to St. John's Hospital for Diseases of the Skin, has been appointed Consulting Physician to the Association for the Supply of Pure Vaccine Lymph.

HOUGHTON, LAMBERT, L.R.C.P., L.R.C.S.Ed., has been appointed Medical Officer of Health for the Amersham Rural Sanitary District, vice Hosegood, whose appointment has expired.

HULL, WALTER, M.B., L.R.C.P., M.R.C.S., has been reappointed House-Surgeon to St. Thomas's Hospital.

JOHNSTON, G. D., L.R.C.P., M.R.C.S., has been appointed Ophthalmic Clinical Assistant to St. Thomas's Hospital.

KIDD, H. CAMERON, L.R.C.P., M.R.C.S., has been appointed Clinical Assistant in the Ear Department, St. Thomas's Hospital.

LEEMING, ROBERT W., B.A., M.B.Cantab., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer to the Kendal District Union and Workhouse, and Public Vaccinator to the Kendal District.

LOWE, ALEXANDER, M.B., C.M.Glas., has been appointed Medical Officer for the Llanelly District of the Crickhowell Union.

LUCAS, SAMUEL ADAMS, L.R.C.P., L.R.C.S.Ed., has been appointed Medical Officer for the Second District of the Parish of Liverpool, vice Kennedy.

LYON, T. GLOVER, M.A., M.D.Cantab., L.R.C.P., M.R.C.S., has been appointed Non-resident House-Physician to St. Thomas's Hospital.

MACDOUGALL, AYMER R., M.B.Ed., M.R.C.S., has been appointed Surgeon to the Chesterfield and North Derbyshire Hospital.

PETHERICK, WALLACE, L.R.C.P.Lond., M.R.C.S., has been appointed Medical Officer for the Hopton and Hepworth District of the Thetford Union, vice Gurdon.

PRIESTLEY, JOSEPH, B.A., M.B., M.R.C.S., has been appointed Resident Medical Officer to the Chelsea Hospital for Women, vice James Harper, M.D.Lond.

PLOWMAN, S., L.R.C.P., M.R.C.S., L.S.A.Lond., has been appointed Clinical Assistant in the Throat Department, St. Thomas's Hospital.

REES, HUGH, M.R.C.S., L.S.A.Lond., has been appointed Medical Officer of Health for the Menai Bridge Urban Sanitary District.

RITCHIE, E. D., B.C.Cantab., M.R.C.S., L.S.A.Lond., has been appointed Assistant House-Surgeon to St. Thomas's Hospital.

ROBERTS, EDWARD, M.R.C.S., L.S.A.Lond., has been appointed House-Surgeon to the Manchester Royal Eye Hospital, vice A. Hill Griffith, M.D.Aberd., resigned.

ROBINSON, H. B., L.R.C.P., M.R.C.S., has been reappointed Resident House-Physician to St. Thomas's Hospital.

ROUSE, ROLLA E., M.B., M.R.C.S., L.S.A.Lond., has been appointed Resident Accoucheur to St. Thomas's Hospital.

SANGYOSHI, Y., L.R.C.P., M.R.C.S., has been appointed Non-resident House-Physician to St. Thomas's Hospital.

STADDON, J. R., L.R.C.P., M.R.C.S., has been appointed Assistant House-Physician to St. Thomas's Hospital.

STEVENS, ARTHUR FREDERICK, M.R.C.S., has been appointed Medical Officer for the Sapistone District of the Thetford Union.

VACHELL, R., M.D., has been appointed Out-patient Medical Officer to the Glamorganshire and Monmouthshire Infirmary and Dispensary, vice T. Wallace, M.D., resigned.

VAN BUREN, ERNEST C. HAWARD, L.R.C.P.Ed., M.R.C.S., has been appointed Assistant Medical Officer to the Workhouse of St. Mary Abbotts, Kensington, vice Atkinson.

WALLACE, T., M.D., has been appointed Surgeon to the Glamorganshire and Monmouthshire Infirmary and Dispensary.

WILLIAMS, R. M., L.R.C.P., M.R.C.S., L.S.A.Lond., has been appointed Resident House-Physician to St. Thomas's Hospital.

WILSON, ARTHUR CORDEN JORDAN, L.R.C.P.Ed., M.R.C.S., has been appointed Medical Officer for the Penistone District of the Penistone Union, vice Watson.

Births, Marriages, and Deaths.

BIRTHS.

AUSTIN.—On the 25th inst., at West Norwood Lodge, Knight's-hill, Lower Norwood, the wife of J. A. Austin, M.D., prematurely, of a son (stillborn).

COLLENETTE.—On the 6th inst., at Silverdale, Staffs., the wife of F. de Beauchamp Collenette, L.R.C.P.Lond., &c., of a daughter.

LUCY.—On the 20th inst., at The Elms, Enfield, the wife of William C. Lucy, M.D., C.M., of a son.

PRATT.—On the 15th inst., at Gibraltar, the wife of Surgeon W. Simson Pratt, Army Medical Staff, of a daughter.

PRITCHARD.—On the 26th inst., at Heath-rise, Hampstead, the wife of Urban Pritchard, M.D., F.R.C.S., of a son.

WADE.—On the 21st inst., at the County Asylum, Wells, Somerset, the wife of A. Law Wade, M.D., Superintendent, of a son.

WARD.—On the 24th ult., at Neemuch, Central India, the wife of Surgeon-Major E. C. R. Ward, F.R.C.S.I., Medical Staff, of a daughter.

MARRIAGES.

EDWARDS—KEMP.—On the 9th inst., at Tientsin, China, R. Henry Edwards, M.B., C.M., to S. Florence, third daughter of the late G. T. Kemp, of Beechwood, Rochdale.

JONES—COLE.—On the 30th ult., at St. Mary's Church, Brighton, Hermann Johnston Jones, M.D., M.R.C.S.Eng., L.R.C.P.Lond., to Hannah Cole, of Notting-hill, W.

MORGENROOD—REID.—On the 25th ult., at Capetown, Edward Henry Morgenrood, M.D., son of the late Philip Morgenrood, of Wynberg, Cape Colony, to Marian Beatrice (Minnie), youngest daughter of Wm. Wardlaw Reid, of Corra Linn, South Norwood, Surrey.

DEATHS.

BAKER.—On the 19th inst., at his residence, Barham House, Leamington, Robert Large Baker, M.D., F.R.C.S., formerly of Birmingham, aged 65.

BUDD.—On the 21st inst., at Southernhay, Exeter, Samuel Budd, M.D., J.P., in his 79th year.

GREENSILL.—On the 14th inst., at "The Firs," Martley, Worcester, Joseph Moore Greensill, M.R.C.S., &c., aged 28.

LESLY.—On the 20th inst., at Abu-Fatmeh, on the Lower Nile, of enteric fever, Robert Lesly, M.D., Army Medical Department, the youngest son of the late William Sole, M.D., F.R.C.S., and of Anne, his wife, now of St. Mary's, Southampton, aged 29.

NICHOLLS.—On the 20th inst., at Devizes, J. F. Nicholls, M.D., aged 65.

THORBURN.—On the 26th inst., at his residence, Moss House, Rusholme, John Thorburn, M.D., Professor of Obstetric Medicine in the Owen's College, Victoria University, Manchester, aged 51 years. Friends will please accept this the only intimation.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.

Medical Diary for the ensuing Week.

Monday, June 1.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10.30 A.M., and each day at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M., and each day at the same hour.

ST. MARK'S HOSPITAL.—Operations, 2 P.M., and on Tuesdays at the same hour.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Prof. Edward Lund: On some of the Injuries and Diseases of the Head and Neck, Genito-Urinary Organs, and Rectum.

ROYAL INSTITUTION.—5 P.M. General Monthly Meeting.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.—8 P.M. Casual communications by Messrs. W. St. George Elliott, C. W. Dunn, A. Maggs, S. J. Hutchinson, and F. Canton.—Mr. C. S. Tomes: On Experiments on Amalgam Fillings.—Dr. G. Field: Pivot Teeth attached by Cohesive Gold.

Tuesday, June 2.

GUY'S HOSPITAL.—Operations, 1.30 P.M., and on Friday at the same hour. Ophthalmic Operations on Mondays at 1.30 and Thursdays at 2 P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.

CANCER HOSPITAL, BROMPTON.—Operations, 2.30 P.M.; Saturday, 2.30 P.M.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

ROYAL INSTITUTION.—3 P.M. Prof. Gamgee: Digestion and Nutrition.

Wednesday, June 3.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M., and on Saturday at the same hour.—Ophthalmic Operations on Tuesdays and Thursdays at 1.30 P.M.

ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Skin Department: 9.30 A.M., on Tuesdays and Fridays.

ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M., and on Saturday at the same hour.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Saturday, 2 P.M. Skin Department: 1.45 P.M.; Saturday, 9.15 A.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 3 to 4 P.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Prof. Edward Lund: On some of the Injuries and Diseases of the Head and Neck, Genito-Urinary Organs, and Rectum.

OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Specimens will be shown. Dr. John Williams: Serous Perimetritis.—Dr. Matthews Duncan: The Hypertrophies of Lupus of the Female Pudendum.—Mr. W. S. A. Griffith: Notes on a Specimen of the Pseudo-Osteo-Malacic Pelvis of Naegele.

Thursday, June 4.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Surgical Consultations, 1.30 P.M.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

NORTH-WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

ROYAL INSTITUTION.—3 P.M. Prof. C. Meymott Tidy: Poisons.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 P.M. Living Specimens.—8.30, P.M. Adjourned Discussion on the President's paper on Reflex Ophthalmitis.—Mr. Spencer Watson: Intra-ocular Gumma in a Child the subject of Inherited Syphilis.—Mr. J. B. Lawford: Tubercle of Choroid.—Dr. W. A. Brailey: Double Retinal Glioma resulting in the Shrinking of one Eye and the Perforation of the other by a large Growth from within.—Communication by Mr. G. A. Critchett: Case of Extreme Retinal Irritability with Abnormal Visual Phenomena.

Friday, June 5.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1.30 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Prof. Edward Lund: On some of the Injuries and Diseases of the Head and Neck, Genito-Urinary Organs, and Rectum.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—8 P.M. Dr. J. Syer Bristowe: Hysteria and its Counterfeit Presentments (Cavendish Lecture).

ROYAL INSTITUTION.—9 P.M. Prof. Dewar: Liquid Air.

Saturday, June 6.

KING'S COLLEGE HOSPITAL.—Operations, 1 P.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

MIDDLESEX HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—3 P.M. Rev. C. Taylor: "The Teaching of the Twelve Apostles," an Ancient Document, with Illustrations from the Talmud.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, May 28th, 1885.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
May 22	29·21	S.E.	49	48	82	55	47	·37	Raining
,, 23	29·64	W.	54	49	108	59	45	·13	Cloudy
,, 24	29·91	S.W.	56	49	100	61	45	·13	Cloudy
,, 25	30·17	S.W.	55	49	74	57	45	...	Raining
,, 26	29·93	W.	57	54	98	66	49	·10	Overcast
,, 27	30·00	W.	57	54	112	72	54	....	Overcast
,, 28	29·90	W.	66	60	...	...	56	...	Cloudy

Notes, Short Comments, & Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

MEDICAL MEN IN NEW SOUTH WALES.

FROM information published by the Immigration Office, Sydney, New South Wales, it appears that in the cities and larger townships of the Colony there is no lack of competent medical men, but in the newer and more remote districts they are too often conspicuous by their absence, and it is by no means unusual for the inhabitants of such places to advertise their willingness to guarantee a certain amount of income to a resident doctor. An experienced medical man, willing to "rough it" for a few years, will attain a competency much more rapidly than in England, especially if devoted to his profession and skilled in the treatment of complicated cases. Medical specialists possess a wide field in Australia, where institutions for the treatment of eye and ear diseases, &c., are practically unknown.

Mr. E. E. Wadbrook is referred to a general notice at the head of this column.

COCAINE TABLETS.

To the Editor of THE LANCET.

SIR,—I can fully confirm Dr. Dolan's experience of the value and efficacy of the cocaine tablets. I have recently made some observations with them, which I trust may be of interest. I dissolved one of the one-sixth-grain tablets in three minims of water, and introduced it into my left eye. There was no pain or irritation; but in from two to three minutes there was well-marked anæsthesia, so that I could touch the conjunctiva with the point of a sharp penknife without experiencing inconvenience. In five minutes dilatation of the pupil was noticed, and at the expiration of ten minutes it was complete, there being at the same time paralysis of accommodation. The anæsthesia lasted for thirty-five minutes, and the dilatation for four hours. With the one-tenth-grain tablets the symptoms were of the same nature, but less pronounced. I find, with Dr. Dolan, that it is not necessary to dissolve the tablets in water, but that they may be introduced directly into the eye without inconvenience. I have used them frequently in the casualty department with most gratifying results. They are admirably adapted for the removal of foreign bodies from the eye, the pain and photophobia being at once allayed. In one case especially, where the patient's eye was full of unburnt gunpowder, the result of an explosion, the relief was very marked. Injected hypodermically, a ligature having been previously applied to a limb, these tablets induce an amount of local anæsthesia sufficient for the performance of small operations, such as the opening of an abscess. I have never seen any untoward effect from the use of the drug, and have myself taken as much as three grains at a dose hypodermically without inconvenience. In the treatment of neuralgia of the eyeball cocaine is, in my experience, by far the best remedy.—I am, Sir, your obedient servant,

EBER CAUDWELL,
Assistant House-Surgeon to the Westminster Hospital.

May 26th, 1885.

THE CASE OF STRANGULATED HERNIA AT STOCKPORT.

IN an annotation in our issue of the 9th inst. we directed attention to a case of umbilical hernia reported in the daily papers. The observations there made were suggested by the evidence which reached us, and we took occasion to state that we might not have been fully informed of the facts. From information since received, it appears that Mr. Buist succeeded twice in reducing the rupture within a few days of the suddenly fatal issue. Herniotomy for strangulated umbilical rupture is an exceedingly unpromising procedure; and yet we think it preferable to leaving the patient to the chances of spontaneous reduction when taxis has failed. Such cases are indeed difficult to deal with, and for that reason we freely admit that at most Mr. Buist committed an error of judgment in not consulting some senior member of the staff of the Stockport Infirmary, of which institution he is a valued officer. It is matter of regret that a post-mortem examination was not made, and the pathological facts placed beyond surmise.

L.R.C.P.—Our advertising columns often contain announcements of the kind indicated. Otherwise we know of no such institutions save those enumerated in the Medical Directory.

Mr. Arthur T. H. Trevor is thanked for his correction of a quotation.

Dr. Cobbold.—Too late.

"NO DOCTORS AMONG THE PEERS."

To the Editor of THE LANCET.

SIR,—I was greatly struck by an annotation under this heading which appeared in THE LANCET of the 16th inst. It seems to me that unless the leaders of the profession of medicine and surgery make a decided stand for their dignity misconceptions will continue to exist with regard to the true status of the profession. When medicine and surgery were practised by illiterate men, who were barbers as well as bleeders, there was perhaps an excuse for the absence of State recognition. But now there is an impassable barrier to prevent such persons being identified with the "healing art." Our noble profession can only be entered as the result of a thorough course of practical training and of passing a series of searching examinations at universities or colleges. Hence it is that at the present day its members include men of the highest intellectual culture and social position; men who have made their mark in the world of science by their discoveries and research for the alleviation of human suffering and the preservation of human life. I allude to such men as Jenner, Paget, Gull, Lister, Spencer Wells, Clark, Bowman, Playfair, Thompson, and many others. With such illustrious names I fail to see why science should not be represented among the peers as a tribute to science, just as literature is represented, and indeed all the learned professions. Moreover, I fail to see why the profession of medicine should not hold at least as high a place in the public estimation, and therefore in that of the State, as any other profession; as, for instance, the Army, the Navy, the Bar—ay, even the Church itself. But as regards State recognition, the medical profession, in comparison with the others, comes last of all. Again, in the House of Commons, while there are upwards of 120 barristers and 100 military men, there are only four medical men. The public can easily judge what a gain it would be to the community to have the benefit of the experience of medical men in legislating for the prevention of disease and the promotion of the health and comfort of the working-classes. How many important medical subjects are continually being discussed in that legislative council from time to time?—in many instances decided by those whose knowledge must be immeasurably inferior to that of men who have devoted their lives to the subjects in question. Among the many subjects about to be brought before Parliament, and which emphatically demand the best attention of a sound medical opinion, are the following:—The Medical Acts Amendment Bill; the health and management of prisoners; the treatment of habitual drunkards; overcrowding, and the proper housing of the working-classes in cities; the further restriction as to the pollution of rivers; the opposition to compulsory vaccination; and last, not least, the vivisection question.

For the foregoing reasons I repeat that our scientific profession—shall I not say the most scientific and enlightened of the present day—should be properly and fairly represented in both Houses of Parliament, as are the sister professions, to assist in deciding great and momentous questions. It seems to me that nothing but the blindest prejudice—a prejudice unworthy of enlightened statesmen—can have so long stayed the hand of the Sovereign, and prevented the elevation of the representative men of our order to seats in the Upper House, which Lord Salisbury once told the country "was chiefly valuable because it represented success in all lines of public usefulness, from commerce to statesmanship." The late Lord Beaconsfield, too, stated, in a speech delivered on Nov. 9th, 1875, that "a policy that diminishes the death-rate of a great nation is a feat as considerable as any of the decisive battles of the world." The present Prime Minister, Mr. Gladstone, has frequently spoken in strong terms of admiration of the increasing importance of medicine and the medical and surgical professions. "That profession," he said, "presented a future of the highest interest. There was in that future the probability that it would gain increased influence, greater as compared with other professions."

The remarkable incident recently reported, of a peer requiring medical assistance in the House of Lords, when Lord Spencer, with great presence of mind, secured the services of a professional commoner from the Lower House, is certainly not my reason why life medical peerages should be created in the same way as legal life peerages have been; but I take the far higher ground—the rights of the medical profession to equal rank and position with any other. If the rights of the profession are not acknowledged, then we ought to endeavour to induce more of its members who can afford it to enter the House of Commons, and, by well-directed combination, show the State that the profession has a political influence if it chooses to exercise it.—I am, Sir, yours truly,

LAMBERT HEPENSTAL ORMSBY,
Dublin, May 23rd, 1885. M.D.Univ. Dub., F.R.C.S.

To the Editor of THE LANCET.

SIR,—With reference to the annotation in your issue of the 16th inst., under the above heading, I beg to express my full accord with your sentiments. Nor do I suppose that many of our body would dissent. Although the powers that be may think that to give a doctor a baronetcy is an honour to the profession sufficient to its needs, still I venture to submit that we honour the powers by accepting it. And so far from feeling hurt at the Premier's remark that you quote, I think we may well afford to treat it as an ignorant and childish insult. For though in whatever country we may practise we are subject to the laws of that country, still our interests do not cease there. We are all the world over members of the same united body, which has for its aim the consummation of science and art in their relation to humanity, the imitation of the highest attribute of the Deity. And as such we can happily remain unhonoured by those who are unable to conceive our high and noble aims, and *sine honore* we need none of us hesitate in feeling our superiority over any of our patients be they kings or paupers. Earthly honour we seek not, we seek but a clear conscience and a true understanding of the Supreme Being.—I am, Sir, yours obediently,

"MAGNUM ET GLORIOSUM EST PRO PROFESSIONE VIVERE."
May 26th, 1885.

THE UNIVERSITY OF NAPLES.

THE number of students entered at the University of Naples for the current scholastic year is 3627. Of these, 1472 are law students, and 1383 students of medicine, the remainder being distributed through the scientific and classical schools.

J. W. (Stoke-on-Trent).—We do not prescribe. Avoid advertising quacks.

An Old Subscriber.—We regret we have not the information at hand.

Mr. Bellamy.—Yes.

COCAINE IN HAY FEVER.

To the Editor of THE LANCET.

SIR,—In your issue of May 16th one of your correspondents asks whether the application of a weak solution of cocaine to the conjunctivæ and the mucous membrane of the nose would be likely to prove beneficial to sufferers from hay fever. Within the last three weeks I have had two cases which would seem to indicate that the remedy in question might fairly be tried, and with a reasonable prospect of success. The first case was that of a lady who for three weeks had suffered from neuralgia, in which the supra-orbital and infra-orbital nerves were affected. Under treatment she made a good recovery, save that on the right side of the nose, at the junction of the bone and cartilage, there was left a constant aching so severe in character as to prevent rest or sleep. I ordered the affected part to be painted with a 2 per cent. solution of cocaine every twenty minutes; after the fifth application the pain entirely ceased. The cocaine was also applied to the mucous lining of the nostril on the affected side. Five days ago another lady consulted me for a painful affection of the nose on the right side, the pain radiating underneath the eye. It came suddenly, and disappeared suddenly, three or four times in the course of twenty-four hours, and was invariably preceded by severe fits of sneezing. This lady assured me that she sometimes sneezed as many as twenty times consecutively. I ordered the nose and cheek to be painted with a 2 per cent. solution of cocaine, and the mucous membrane of the affected side to be brushed over with the same. After four applications, the sneezing became less violent, and for two days she was free from the annoyance. I think the cocaine solution has been beneficial, and in such cases should be tested. In cases of hay fever it is worthy of a trial; but I should, in the first instance at least, confine its application to the lining membrane of the nose.

I am, Sir, yours respectfully,
Strathmore, Harrogate, May 21st, 1885. A. G. RUSSELL.

THE VOLUNTEER MEDICAL SERVICE.

To the Editor of THE LANCET.

SIR,—"A Volunteer Surgeon" asks, in your issue of the 16th inst., to be recommended the books containing the details necessary to be acquired in order to obtain the pass certificate for Volunteer surgeons. As the requirements have increased considerably during the last few years, I would advise your correspondent to apply direct to the principal medical officer of his district, who will give every assistance in his inquiries. The present requirements necessitate a knowledge of all the details of the bearer company, general hygiene of a camp, medical aid in the field, and the regulations connected with military hospitals as detailed in the Medical Regulations, which unfortunately are out of print. A new edition of the "Stretcher-bearer Drill" now general in the Volunteer force is about to be issued. A knowledge of this drill in all its details would also be required. Many of the minor matters connected with marches, diet, filtration of water, &c., are discussed in Parkes' Hygiene, which work, with the hospital portion of Longmore on Gunshot Wounds, is recommended to be obtained.—Yours truly,

May 25th, 1885. A VOLUNTEER SURGEON-MAJOR.

DOCTORS *v.* PHYSICIANS.

To the Editor of THE LANCET.

SIR,—In your issue of the 25th ult. appeared two letters on the above topic. As they are written in much the same strain, they may conveniently be considered together. An attempt is made to create, or to encourage, an unfriendly spirit, by advising the use of mean expedients by the holders of one qualification to depreciate and annoy the possessors of another. Let the M.D. of somewhere consider himself vastly superior to his neighbouring L.R.C.P.Lond. if he likes; but he certainly has no right to employ every available opportunity for using either the snub direct or oblique, as recommended by one of your correspondents. With your permission, I will recount a tale and point a moral.

A few years ago I entered one of the largest London hospitals, having previously had two years' training at a public dispensary in the metropolis. I thought that in due course I should be able to get a doctor's degree. I found, however, the London University closed to me, unless I gave up a deal of valuable time to reading for the Preliminary Scientific examination. Deeming that my object in entering the hospital was to render myself a trustworthy practitioner of medicine rather than the temporary possessor of biological minutiæ, I resolved to give up the quest, and to go in for the L.R.C.P.Lond. and M.R.C.S., the only good qualifications open to me without interrupting my studies by leaving London. Some of my fellow-students, with an amount of worldly wisdom, seeing not only that the London degree was impossible for them, but that the London Colleges were beyond their reach, went to Scotland, where they and their fees were welcomed; and in due time these men returned with their M.B., C.M., only to wait a short time, when they would without any effort ripen into the higher degree. Now, only one of these graduates held any clinical appointment at the hospital, and, with that one exception, they would be classed among the non-industrious men of their year. In the meantime, many of us remained in London, steadily working through the clinical appointments and getting our qualifications.

I will now ask, Why are we, who are every whit as well educated and professionally qualified as the majority of M.D.'s, and better than some, to be spoken of as little better than impostors because we elected not only to commence but to pursue our professional education in London rather than elsewhere? It may be remarked in passing that even the M.R.C.P. is closed to us, as the holder of it is precluded from general practice. I trust the time is not far distant when we physicians will be taken out of our present false position and given a title of some real value. It is certain that if something is not done in this direction our London schools will wane with increasing rapidity.

I am, Sir, your obedient servant,

May 20th, 1885. PHYSICIAN AND SURGEON.

SYPHILITIC INDURATION OF A CICATRIX RESEMBLING MORPHŒA.

To the Editor of THE LANCET.

SIR,—The following case is of some interest as indicating a possible close connexion between morphœa—especially those cases which disappear comparatively rapidly—and syphilis.

A. B——, aged forty, had the left arm injured by cogwheels, the skin and cellular tissue on the outer side near the elbow being divided by several parallel cuts. About a month after the wounds had completely and soundly healed the cicatrix became indurated, and instead of being thin and soft, appeared half an inch or more in thickness, and closely resembled morphœa. I found that the patient had had a hard chancre a short time previously, the remains of which were still evident. Under antisyphilitic treatment the induration of the cicatrix on the arm began to disappear, and after some weeks the cicatrix resumed its normal appearance.

In the absence of evidence of recently acquired syphilis, I should have been compelled to diagnose the foregoing case as one of ordinary morphœa following an injury and developing in the cicatrix.

I am, Sir, yours obediently,

Nottingham, May 25th, 1885. H. HANDFORD, M.D.

MAHOMED MEMORIAL FUND.

DR. AUSTIN FLINT of New York has forwarded to us the sum of £1 in aid of the above fund.

Dr. Ferris of Uxbridge is thanked for his letter and enclosure. Our remarks, as he perceived, were written on the ground that the period of incubation in his case was unusually long even for hydrophobia.

W. M. has not enclosed his card.

Dr. J. A. Gray (Atlanta).—We cannot extend our exchange list.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. Chaplin, Jerusalem; Dr. E. Crookshank, Dresden; Dr. Russell Reynolds, London; Dr. Cobbold, London; Dr. Ewart, London; Mr. Barwell, London; Dr. Collingridge, London; Mr. Jackman, Coggeshall; Dr. Handford, Nottingham; Dr. Prosser James, London; Dr. Oliver, Harrogate; Mr. De Méric, London; Mr. Twyford, Hanley; Mr. Field, London; Mr. Turner, St. Petersburg; Dr. Thin, London; Mr. C. J. Stocker, Forest Gate; Mr. Chavasse, Birmingham; Mr. St. John Wright, London; Mdlle. V. de Bunsen; Mr. W. Steer; Dr. Savage, London; Mr. B. Pollard, London; Dr. Brailey, London; Mr. Percy Dunn, London; Mr. P. J. Thompson, Brussels; Mr. Somers Vine, London; Mr. W. P. Fox, Liverpool; Mr. B. Squire, London; Dr. J. Tily, Chiswick; Dr. Colquhoun, Dunedin; Dr. H. E. Armstrong, Newcastle-on-Tyne; Mr. P. W. Macdonald, Dorset; Mr. A. C. Munro, South Shields; Dr. Ormsby, Dublin; Mr. C. S. Jeaffreson, Newcastle-on-Tyne; Dr. J. D. Thomas, London; Dr. Irwin; Mr. Brocklehurst, Matlock; Mr. Furland; Mr. Fairman, Bruntsfield; Mr. Prodham, London; Dr. Diver, Keighley; Mr. Green, Derby; Mr. Lonergan, Hythe; Lieut.-Gen. Radcliffe, Leamington; Messrs. Oliver and Co., Manchester; Mrs. Goff, Birkenhead; Messrs. Calvert and Co., Manchester; Mr. Gordon, Devonport; Mr. Evans, Oswestry; Mr. Ulbrich, Pullna; Messrs. Oliver and Boyd, Edinburgh; Mr. Lowndes, Newcastle-on-Tyne; Mrs. Martin, Middlesbrough; Messrs. Griffin and Co., London; Messrs. Lee and Martin, Birmingham; Dr. Gledhill, Manchester; Mr. Davies, Bath; Mr. Gallahier; Messrs. Douglas and Mason, Edinburgh; Dr. Halkin, Inverness; Messrs. Reynolds and Branson, Leeds; Dr. Squire, London; Mr. Anderson, Llandudno; Dr. Mackew, Paris; Mechanic; L.R.C.P.; Oil Immersion; Volunteer Surgeon-Major; G. B. P.; W. M.; D. M. P.; B.; J. A. T., Hampstead.

LETTERS, *each with enclosure*, are also acknowledged from—Dr. Kerr, London; Mr. Allen, New Brighton; Dr. Maskew, Romsey; Mr. Wood, Chelsea; Mrs. Woodcock, Ryde; Miss Rimmer, Wigan; Mr. Mason, Highbury; Mrs. Brown, Walthamstow; Mr. Wright; Dr. Eberle, Thirsk; Mrs. Griffith, London; Mr. Denne, Halesowen; Mr. Soper, Dartmouth; Mr. Gallagher, Bishop Auckland; Dr. Robertson, Sheffield; Mr. Ferguson, Cheltenham; Dr. Brockhurst; Mr. Jennings, Port Harlington; Messrs. Maguire and Son, Dublin; Mr. Birchall, Liverpool; Mr. Fidler; Mr. Parry; Mr. Myers, Great Grimsby; Mr. Lawson, London; Miss Rogerson, Newton-le-Willows; Mrs. James, St. John's Wood; Mr. Sutton; Mr. Rahn, Ipswich; Messrs. Austin and Sons, Clifton; Messrs. Mackay and Co., Edinburgh; Mr. Mayo, Great Yarmouth; Messrs. Porteus and Co., Glasgow; Messrs. Byles and Son, Bradford; Albus, Leicester; Theta; Stratton, Birmingham; H. S. R.; L.R.C.P.E.; Matron, St. Helens; F. C., Halifax; M.D., London; G.W.R.; F.R.C.S., Edinburgh; F.S.A., Wye; G. B.; M.D., Draycott; Undergrad., Arbroath; Secretary; Physician, Southwark; Medicus, Wiston; E. D. C., Wednesbury; J. R.; A. B., Whitechapel; Delta, Christchurch; R., St. Helens; Physician; A. B. C., Notting-hill; J. G.; House, Brighton; A. H., Brixton; A. P.; C.

New York City Record, Newcastle Daily Chronicle, Edinburgh Evening Express, Church of England Temperance Chronicle, Auckland Chronicle, Elgin Courant, Florida Times-Union, Gloucestershire Chronicle, North Devon Journal, Darlington and Stockton Times, Liverpool Evening Express, Croydon Advertiser, Croydon Chronicle, The Crofter, &c., received.

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Half a Page	2 15 0
An entire Page	5 5 0

The Publisher cannot hold himself responsible for the return of testimonials, &c., sent to the office in reply to advertisements; copies only should be forwarded.

NOTICE.—Advertisers are requested to observe that it is contrary to the Postal Regulations to receive at Post-offices letters addressed to initials only.

An original and novel feature of "THE LANCET General Advertiser" is a special Index to Advertisements on page 2, which not only affords a ready means of finding any notice, but is in itself an *additional* advertisement.

Advertisements (to ensure insertion the same week) should be delivered at the Office not later than Wednesday, accompanied by a remittance.

Answers are now received at this Office, by special arrangement, to Advertisements appearing in THE LANCET.

Terms for Serial Insertions may be obtained of the Publisher, to whom all letters relating to Advertisements or Subscriptions should be addressed.

Advertisements are now received at all Messrs. W. H. Smith and Son's Railway Bookstalls throughout the United Kingdom, and all other Advertising Agents.

Tables of Contents, with the Index of Advertisements, for each Number can be had on application to the Publisher.

Agent for the Advertising Department in France—J. ASTIER, 66, Rue Caumartin, Paris.